LEGISLATIVE HEARING ON H.R. 862, H.R. 1406, H.R. 1435, H.R. 1746, H.R. 1929, H.R. 2359 AND H.R. 2361

HEARING

BEFORE THE

SUBCOMMITTEE ON BENEFITS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

JULY 10, 2001

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LEGISLATIVE HEARING ON H.R. 862, H.R. 1406, H.R. 1435, H.R. 1746, H.R. 1929, H.R. 2359 AND H.R. 2361

TUESDAY, JULY 10, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON BENEFITS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Mike Simpson (chairman of the subcommittee) presiding.

Present: Representatives Simpson, Reyes, Evans and Snyder.

OPENING STATEMENT OF CHAIRMAN SIMPSON

Mr. SIMPSON. Good morning. This hearing will come to order. It is nice to be chairman of the subcommittee. I found out that the chairman has a much more comfortable seat than all the other seats around here. So if that is the only reason you become chairman, I guess that is a good reason, isn't it?

Mr. REYES. Absolutely.

Mr. SIMPSON. We are meeting this morning to take testimony on a number of bills before the Subcommittee on Benefits. Before I turn to the Ranking Member, Mr. Reyes, I would like to tell you a little bit about myself as the new chairman.

As you are all aware, J.D. Hayworth has resigned the committee in order to take a position on the Resources Committee. J.D. has always been a strong advocate for veterans, and I am sure he will continue to be an ardent supporter of the committee's agenda.

When Chairman Smith called and asked if I would be interested in chairing this subcommittee, I accepted immediately. Regardless of party affiliation, we have one goal and one goal only on this committee, and that is doing right by the veterans and their dependents. It is my hope that we can continue to work in the bipartisan fashion the Veterans' Affairs Committee is so well known for. I especially look forward to working with Mr. Reyes, a Vietnam combat veteran and one of the real gentlemen of Congress.

I began my political career in 1980 when I was elected to the Blackfoot City Council. Four years later, I was elected to the State Legislature of Idaho, where I served for 14 years, 6 years as Speaker of the House of the Idaho Legislature. I continued my work as a dentist in the practice started by my father and uncle. I am currently serving my second term here in Congress, and I represent the Second Congressional District of Idaho.

And if anybody wants to know or has any plans, I am an avid golfer. So if there is any—I am a 6 handicap, and I am looking—let me see. I think the Senior Tour starts when you are 50 years old. So that just started when I was—turned 50. So I'm ready, and if anybody can get me on the Senior Tour, we are ready.

Now to the business at hand. We are receiving testimony today on several bills covering a wide array of veterans' benefits, and I look forward to hearing the views of our witnesses. I will ask that the witnesses' remarks be limited to no more than 5 minutes. And without objection, the witnesses' entire statements will be included in the hearing record.

Before we begin—bring up the first panel, I would like to briefly summarize each bill we will be discussing today. H.R. 862 would add Type 2 diabetes to the list of diseases presumed to be service-connected for veterans exposed to Agent Orange and other herbicide agents.

H.R. 1406 addresses Persian Gulf War illness issues.

H.R. 1435 and H.R. 1746 both address providing veterans a toll-free number which they can call and access full benefits information.

Due to scheduling conflicts, Mr. Baker and Mrs. Capps were not able to be with us in person to discuss these two bills, but they have both submitted statements for the record. Mr. Baker is the chief sponsor of H.R. 1746, and Mrs. Capps introduced H.R. 1435.

Mr. Udall will be here this morning, as we understand it, to testify on his own bill, H.R. 1929, the Native American Veterans Home Loan Act of 2001. And I want to thank Tom, when he gets here, for taking part in this hearing and for his participation in veterans' affairs and his interest thereon.

H.R. 2359 makes minor program changes to the National Service Life Insurance and United States Government Life Insurance programs, the Native American housing loan pilot program, and the Court of Appeals for Veterans Claims appellate process. And finally, H.R. 2361 is the Committee's annual cost-of-living adjustment legislation for service-connected veterans and their survivors.

We certainly have a full agenda today and that is good. I would now recognize Mr. Reyes, the subcommittee's Ranking Member, for any opening remarks that he may wish to make.

OPENING STATEMENT OF HON. SIVESTRE REYES

Mr. REYES. Well, thank you very much, Mr. Chairman, and welcome to our Subcommittee on Benefits. I look forward to working with you on the issues of the veterans. And just a point of personal information: I, too, am a golfer, and I consider myself a scratch golfer. Every time I hit the ball, I scratch and say, How the heck did that ball go there? So maybe we can get together and play some golf and you can—you can teach me a few lessons.

Mr. SIMPSON. We can do that.

Mr. REYES. But I appreciate also our colleagues being here, and as an original cosponsor and strong supporter of a number of the bills that are being heard today, I am pleased that we are holding this hearing, Mr. Chairman.

I support including diabetes mellitus, Type 2 as a statutory presumption for veterans exposed to Agent Orange. While I congratu-

late the Secretary of Veterans Affairs for his prompt action in providing a presumption for diabetes in regulation, I still believe that we should provide veterans with a statutory presumption.

I also strongly support H.R. 1406. Both Chairman Bob Stump, who was the former chairman of the full committee, and Lane Evans, our ranking Democrat, have criticized VA's unduly restrictive interpretation of the definition of "undiagnosed illness." this statutory change is essential to stop the practice of making different determinations of eligibility for compensation benefits depending on whether a set of symptoms is attributable to an "undiagnosed" or "poorly defined" condition.

I recognize that the ill-defined nature of many of the symptoms experienced by Gulf War veterans have led some to conclude that the presumptive period for manifestation of undiagnosed illnesses should be extended beyond December 31, 2001. Most of the veterans filing claims for undiagnosed illnesses are veterans who served in the Gulf during the actual conflict. I am not aware of any veterans who recently began experiencing symptoms of poorly defined illnesses many years after leaving the Gulf, and I am therefore reluctant to support the extension of the presumption for all veterans for another 10 years.

However, based on the slow development of the symptoms after veterans leave the Gulf, I would ask VA and the veterans service organizations to comment on the desirability of providing veterans who have served or serve in the Gulf a 10-year presumption-of-service connection after the last period of service in the Gulf.

I also strongly support the provision to protect veterans participating in VA-sponsored medical research from loss of benefits. I understand the main purpose of H.R. 1435, the Veterans Emergency Telephone Service Act, is to provide crisis intervention and information and referral services to veterans needing immediate assistance. The object of this program would not be duplicate services provided by the VA's current toll-free numbers, but to provide an immediate resource for veterans experiencing a crisis situation.

The issues raised by H.R. 1746, as well as H.R. 1435, indicate to me that the VA's current 1–800 numbers are not working as well as we should expect them to work. According to research by committee staff, veterans can wait for almost one-half hour to have their calls answered. I would also like to hear from the VA concerning the training and information provided to personnel staffing those numbers. In some instances, incomplete or incorrect information has been provided.

I, furthermore, fully support H.R. 1929, which would extend and improve the Native American home loan pilot project. I thank the gentleman from New Mexico, who, I am told, is on his way here, for bringing this matter to the attention of the committee. It is my understanding that the outreach provisions which VA would like removed are essential to the successful operation of this program.

I would therefore propose that we reject the Veterans Administration's request.

I support H.R. 2359, which includes a provision for allowing payment of life insurance proceeds, which VA has been maintaining due to the inability to locate named beneficiaries. This provision is similar to a provision contained in H.R. 2222, the Veterans Life In-

surance Improvement Act of 2001, introduced by Representative Bob Filner, which would allow the VA to pay over 4,000 claims for which the primary and/or secondary beneficiary cannot be found. I would hope that we could eventually consider the other important provisions contained within H.R. 2222. I am also supportive of the provision of H.R. 2359, which is similar to the Udall-Evans bill, H.R. 1929.

I, as well, support the elimination of the requirement for veterans appealing to the court to notify the Secretary of their appeal.

I support providing a cost-of-living increase, comparable to that provided to Social Security beneficiaries. Benefits provided to our Nation's veterans and their families should never be eroded by increases in the cost of living.

Mr. Chairman, I look forward to working with you on these and many, many more issues that are of concern to our veterans. And I look forward to the testimony of our colleagues this morning. Thank you very much, Mr. Chairman.

[The prepared statement of Congressman Reyes appears on p. 75.]

Mr. SIMPSON. I thank the Ranking Member. Veterans can be very glad that both of us play golf, because I have found that more is done on a golf course than anywhere else. So I look forward—we will set an agenda out there that will get the job done.

Mr. REYES. Well, you play. I hack.

Mr. SIMPSON. Congressman Udall is going to be here on our first panel. As soon as he arrives, we will bring him up. Mr. Manzullo is also with us this morning. Although his bill is not on the agenda, he asked if he could stop by to say a few words about H.R. 612.

And, Don, we welcome you and would be glad to hear your testimony this morning.

Mr. MANZULLO. Chairman, first of all, congratulations on your assuming this chairmanship.

Mr. SIMPSON. Thank you.

STATEMENT OF HON. DONALD A. MANZULLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. MANZULLO. We are excited that you are chairing it. And also my good friend and colleague, Mr. Reyes, we have spent a lot of time together on the American-Mexican parliamentary exchange, and he—like me, he doesn't golf; he eats. And so we have a lot of fun doing that.

Chairman Simpson and members of the subcommittee, I thank you for the opportunity to testify on behalf of the legislation I introduced with Mr. Gallegly and Mr. Shows, H.R. 612, the Persian Gulf War Illness Compensation Act of 2001. Ten years ago, a patriot from Freeport, IL, an area that I represent, a young man named Dan Steele, went off to war in Iraq to protect the freedoms that this country has known for more than 20 years—more than 200 years. During the buildup in the Gulf, Dan's leg was fractured by an Iraqi soldier's apparent suicide attack. Over the next 8 years, he suffered from various conditions shared by many other soldiers who fought in the Gulf War.

In May of 1999, Dan succumbed to his illnesses and passed away. We believe he is the youngest Gulf War veteran to die by

what has been known as, quote, "Gulf War Syndrome." The county coroner listed Gulf War Syndrome as the secondary cause of death on his death certificate.

Shortly after Dan's funeral, our office contacted his widow, Donna, and she vowed then that she would do whatever she could so that this would not happen to other veterans. Her story moved me to introduce legislation to compensate our suffering Gulf War veterans.

H.R. 612 is a simple technical correction of the undiagnosed illness compensation law Congress passed in 1994, Public Law 103–446. Congress enacted that law to ensure compensation for Gulf War veterans suffering from unexplained conditions, commonly referred to as "Gulf War Illness." unfortunately, three-quarters of the veterans who have applied for this compensation have been denied because the Department of Veterans Affairs is implementing the law too narrowly.

To solve this problem, the H.R. 612 clarifies the standards for compensation for Gulf War veterans suffering from certain undiagnosed illnesses by defining the term "undiagnosed illness," and extends the presumptive period for undiagnosed illness claims.

The problem with the undiagnosed illness compensation program is not new to the House Veterans' Affairs Committee. On June 3rd of 1998, Chairman Bob Stump wrote the Secretary Togo to protest, in very harsh language, the VA's narrow implementation of the law and request a review of the VA's regulations. H.R. 612 incorporates Chairman Stump's statement of the intent of Congress. Stump's problem with the VA is that once the VA diagnosed a veteran with a poorly defined illness, then a veteran could no longer receive compensation for an undiagnosed illness. Stump added that this practice frustrates the purposes of this law and raises a serious question of deprivation of due process under the Constitution.

The VA's response to Chairman Stump's letter was to issue a confusing and complicated legal opinion.

I practiced constitutional law for 22 years, read and reread and re-reread that opinion several times, over and over and over again; and for the life of me, I have no idea what the VA is trying to say, except they continue to deny claims of people who are worthy of compensation.

I have come to the conclusion that the VA is denying compensation based on the fact that the veteran cannot show the cause of his or her malady. And once a veteran is diagnosed with an illness, even a poorly defined illness, the VA will not compensate that person under Public Law 103–446.

The only thing this legal opinion indicates is, the VA needs specific direction and language from Congress in addition to that very specific language Congress set forth in 1994. The VA does not understand Congress's intention as set forth in the 1994 law. Congress simply wanted to make sure that Gulf War veterans who went off to war and returned with illnesses whose cause cannot be explained should be compensated, period. That is why I introduced H.R. 612 and that is why Senator Kay Bailey Hutchison introduced the very same bill that I drew, and she has been on top of this for years.

Two weeks ago, the VA again demonstrated it does not understand Congress' intention. VA doesn't understand their role. The VA does not make policy; Congress makes policy, and the VA implements it. And they have yet to understand that they are not the makers of policy in this country as to VA issues.

On June 28, Deputy Secretary of Veterans Affairs, Leo Mackay, Jr., testified before the Senate VA Committee on S. 409, that the VA already has the authority to compensate Gulf War veterans adequately. If so, then why is the VA fighting these veterans?

H.R. 612 extends by 10 years the presumptive period for undiagnosed claims. The Federal Government has spent over $150 million on countless studies, and the VA still insists, based upon their language, that an applicant has to show the ideology of his malady.

There is adequate funding to implement H.R. 612, as set forth in the attachment to my testimony. In November of 1999, candidate George Bush made the following statement in his Veterans Day speech: "Veterans need advocates in the VA, people sympathetic to their interests instead of suspicious. If I am elected, that is the kind of veterans official I intend to appoint.

"This applies to veterans of the Gulf War, too. They should not have to go to elaborate lengths to prove that they are ill just because their malady has yet to be fully explained. In 1994, a law was passed to grant them the presumption of disability, yet even now they are met with skeptical looks and paper-shuffling excuses for withholding coverage. If I have anything to say about it, all that is—that is all going to end. In the military when you are called to account for a mistake, you are expected to give one simple answer, no excuse, sir."

Mr. Chairman, why is the VA fighting the President, the Congress, and the veterans? H.R. 612 is the solution to the problem outlined by President Bush in the VA Committee. Two hundred twenty-one Members of the House and all the major veterans groups have signed on to this bill. We have been working on it now for close to 4 years.

Mr. Evans' bill, H.R. 1406, section 2, fills in some of the gaps caused by the VA's misinterpretation of the 1994 law by stating that a veteran is entitled to disability if he or she has been diagnosed with certain ill-defined illnesses, and I commend my colleague from Illinois for the bill. Our bill completes and clarifies Mr. Evans' bill by defining "undiagnosed illnesses" so that our veterans will never again have to fight the VA to get the compensation they deserve and we owe them.

I suggest we replace section 2 of H.R. 1406 with H.R. 612 in its entirety. I believe Section 3 of H.R. 1406, of course, should be maintained. Or you can mark up Mr. Evans' bill minus section 2, and also mark up my bill, H.R. 612, in its entirety.

Mr. Chairman, again, thank you for the opportunity to testify. I would be happy to answer any questions. I would ask that my statement be introduced into the record in its entirety.

[The prepared statement of Congressman Manzullo, with attachments, appears on p. 84.]

Mr. SIMPSON. Without objection.

I thank you for your testimony on this. I can assure you that this committee, and all Members of Congress, are concerned about the illnesses of our veterans that have served in the Gulf War; we will continue to work on this to try to resolve this issue and make sure that those veterans have the benefits that they deserve. So I appreciate your testimony today.

And, Mr. Udall, we will hear your testimony now, and then we will take questions for both of you. Thank you, Tom, for being here today; I appreciate it. Your testimony is on H.R. 1929, the Native Americans Veterans Home Loan Act of 2001, and I appreciate it.

STATEMENT OF HON. TOM UDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. UDALL. Thank you very much, Chairman Simpson, and members of the committee, and thank you for holding this legislative hearing on H.R. 1929, the Native American Veterans Home Loan Act of 2001. It is an honor to testify before the subcommittee today about this important legislation, and I appreciate the opportunity to do so.

Along with 14 of my colleagues, including Ranking Member Lane Evans, I introduced H.R. 1929 on May 21, 2001, to help ensure that the Department of the Veterans Affairs Native American veteran housing loan pilot program is extended. This extension will allow more veterans living on trust lands to take advantage of this important benefit.

The Native American Veterans Home Loan program currently will expire on December 31, 2001. However, the program has sufficient funds remaining under the original appropriation to provide loans for an additional 4 years without requiring any new appropriation. Therefore, the Native American Veterans Home Loan Act of 2001 would extend the direct loan pilot program until December 31, 2005.

Since the inception of the pilot program in 1992, the VA has made 233 direct loans to Native American veterans, which can be used to purchase, construct or improve a home on Native American trust land. The VA direct loans are generally limited to either the cost of the home or $80,000, depending on which is less.

It is worth noting that not one of the homes made possible by this VA direct home loan program has suffered foreclosure. For a veteran to be able to participate in this program, the veteran's tribe must have entered into a memorandum of understanding with the VA. In some cases, however, a tribe may have an existing MOU with an agency other than the VA, but is still required to negotiate a separate MOU.

My goal is to expedite the process of providing home loans and allow more Native American veterans to take advantage of this pilot program. To do this, my bill waives the need for a second MOU, provided that the existing MOU substantially complies with VA requirements.

To date, the VA has entered into MOUs with a total of 59 Native American tribes and Native American groups throughout the country, with MOU negotiations continuing with an additional 24 tribes. Traditionally, veterans living on tribal land, including allotted land, have not been eligible for VA home loan guarantees. How-

ever, the Native American veteran direct loan pilot program has allowed many Native American veterans who might otherwise have been unable to obtain suitable housing to do just that. By extending this direct loan pilot program for another 4 years, H.R. 1929 would provide the opportunity for additional, deserving Native American veterans to benefit from this important VA program.

Thank you for the opportunity of testifying today, and I welcome any questions Members might have.

Mr. SIMPSON. Thank you, Tom. I appreciate your testimony. I can assure you that we will take your comments under advisement on this committee.

[The prepared statement of Congressman Udall appears on p. 105.]

Mr. SIMPSON. Mr. Reyes, I understand that you will be presenting Mrs. Capps' testimony. You may begin.

Mr. REYES. That's correct.

Thank you for that opportunity, Mr. Chairman. My colleague, Representative Lois Capps, regrets that scheduled events in her district prevent her from being here today to deliver her testimony in person. Her extensive written testimony is before us, but please allow me to read a brief summary from Mrs. Capps' testimony:

"I am grateful to Chairman Simpson, Ranking Member Reyes and the subcommittee for the opportunity to comment on two very important bills that are before you today, the Veterans Emergency Telephone Service Act and the Gulf War Undiagnosed Illness Act of 2001.

"H.R. 1435, the Veterans Emergency Telephone Service Act, sets up a 911–411 toll-free national veterans hotline service that can be accessed by veterans in all 50 states 24 hours a day, 7 days a week.".

Current information lines operated by the VA are only available certain hours of the day, Monday through Friday. Crisis intervention services are not provided at all. This hotline "would provide our veterans with immediate and constant access to counseling and crisis intervention services, including suicide prevention, substance abuse, rehabilitation programs and mental health services. It would provide vital information to destitute veterans in need of emergency food and shelter services as well. Some calls may be so desperate, immediate crisis intervention is essential to saving a veteran's life.

"for routine inquiries that are normally and capably handled by existing toll-free numbers at the VA, the 911–411 operators may simply give general guidance and refer the caller to the appropriate VA resource.

This much-needed hotline "has a bargain basement cost of only $2 million per year. This is a small price to pay for the critical urgent assistance that it provides for our veterans.

"by virtue of their service and sacrifice on behalf of this Nation, our veterans deserve the very best support services that we can provide for them, especially in their moments of greatest need. Sadly, such moments don't always occur during regular business hours, Monday through Friday.

"another important bill before you is H.R. 1406, the Gulf War Undiagnosed Illness Act of 2001." this bill would eliminate a classic

Catch–22 situation faced by our veterans and the VA in medical research studies.

Under the current scenario, veterans who are being compensated on the basis of an undiagnosed illness and who participate in a VA-sponsored medical research study could stand to lose their benefits if they are diagnosed with ALS or another condition during the course of that study. At the same time, for the veterans who may have ALS and decline to participate because of the risk of losing those benefits, the data may be insufficient to establish an association and advance our understanding of Gulf War illnesses.

I hope the subcommittee can move forward on both of these important bills for our veterans, and I thank you, Mr. Chairman.

[The prepared statement of Congresswoman Capps appears on p. 106.]

Mr. SIMPSON. Thank you for reading Mrs. Capps' testimony; I appreciate that. I don't have any questions at this time. I would ask the Ranking Member if he has any questions of our panel.

Mr. REYES. I have got a couple of questions, one for my colleague, Mr. Udall.

It has been my experience that in talking about your legislation that among the hardest groups to penetrate, for many different reasons, are the Native Americans. And in the context of your legislation, the VA has made some recommendations to eliminate certain provisions of your legislation that would require, I believe, an MOU.

Can you elaborate for us—the VA will be testifying after you, and I would like to give you an opportunity to give us your thoughts on their recommendation.

Mr. UDALL. Thank you, Ranking Member Reyes.

First of all, just as an initial comment on what you said, one of the biggest difficulties in terms of providing housing for veterans does occur with Native American veterans, and I have that issue in my district. Many of us in the West, like your district in West Texas, there are districts all across the West where this is an issue, and part of the problem is tribal trust land—Native American veterans going back and living on reservations and tribal trust land. And so that has been a big problem.

The issue of the MOU is one that I mentioned in my testimony, and it is one that the Veterans Administration has brought forward. I believe that, rather than requiring these tribes to go through two sets of MOUs, that we can do that with one, so long as the existing MOU substantially complies with VA requirements. So my sense would be that this long-drawn-out process of going through MOUs—and it takes a lot of time—that we could do it with one.

I hope that the Veterans Administration listens to this testimony closely, because I think these additional MOUs slow down the process. It hurts our ability to offer these vitally needed services to veterans. I look forward to hear what they have to say on this particular issue, but I don't know why we wouldn't allow just one MOU when it is—so long as it substantially complies with VA requirements.

Mr. REYES. Thank you, Tom.

Mr. Chairman, I don't know if you have had the same experiences that a number of us have had as it pertains to Native Americans, but you have got issues where Native American veterans that live on reservations are, you know, somewhat isolated. We know that it has been documented that on reservation land the infrastructure is extremely poor, and we are talking about access to even basic telephone services. We are talking about usually a population that is less educated and less sophisticated about their rights and the kinds of programs that are available.

Now, and third, a population that is in probably among the neediest in the Nation in terms of housing, medical benefits, just right down the line, but a population that has very willingly, when called upon, has put their life on the line for this country. That is why I think, instead of objecting to provisions in legislative efforts—and both our colleagues have spoken with some degree of frustration about a system that, instead of being advocates for our veterans, sometimes takes a different tack and actually either tries to set policy or tries to do everything but provide that kind of advocacy and service to our veterans.

That is why I am particularly interested in hearing the testimony of our two colleagues about those frustrations, because I hear it from our veterans all the time. I have had an opportunity to visit with veterans in New Mexico, which is right adjacent to my district in West Texas, in fact, have been with Tom and others in central New Mexico on the reservations; and that really is a tremendous issue and a tremendous problem for that segment of our population. So I hope we do everything we can to facilitate those kinds of services for our veterans.

Mr. UDALL. Chairman Simpson, if I could just make one more comment based on what Congressman Reyes just said.

Many of us don't realize that on these Native American reservations that things that we take for granted in American society—a roof over your head, clean water, a good job—are just not present on the reservation. I mean, 40 percent of the homes on our Indian reservations in this country are substandard homes, so they are in violation of code. They are dilapidated. So this Veterans Home Loan Act tries to provide housing in a very, very crucial area. Unemployment, up to 50, 75 percent on many of my reservations, unemployment; and many of them on the reservations don't even have running water.

So my point is that the basic necessities aren't there, and so the government should try to do everything it can to cut through the bureaucracy and make the program work, and I think this additional MOU is just something that is holding us back in terms of providing good housing.

Thank you very much, Mr. Chairman.

Mr. SIMPSON. I thank you for that, and I can assure you that this committee will be working on those areas with Native Americans.

I have long had an interest and concern about that. The southern border of the town I grew up in is the border for the Fort Hall Indian Reservation, and I have worked out there for probably 15 years as I was growing up and became very familiar with them. During my whole career in the State legislature and here, I have been very concerned with a variety of issues concerning our Native

American tribes; that is one of my high priorities in Congress—to address their concerns in not only this area but many other areas. So I look forward to working with you on that, and I can assure you that the committee will work on that.

I know, Tom, you have been very interested in the Native American issues down in New Mexico, both as chairman and as a Congressman, and so I look forward to working with you on that. Mr. Snyder.

Mr. SNYDER. I have no questions. Thank you, Mr. Chairman.

Mr. SIMPSON. I thank the members for their testimony.

Mr. UDALL. Thank you.

Mr. MANZULLO. Thank you.

Mr. REYES. Mr. Chairman, our colleague, Congressman Evans, had to leave. Can I ask that his statement be entered into the record?

Mr. SIMPSON. Certainly. Without objection.

[The prepared statement of Congressman Evans appears on p. 80.]

Mr. SIMPSON. Will our second panel please come forward?

Mr. Thompson, the Under Secretary for Benefits, is representing the Administration this morning and is accompanied by Dr. Feussner.

Thank you both for your attendance today.

Mr. Thompson, you may begin.

STATEMENT OF HON. JOSEPH THOMPSON, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY DR. JOHN FEUSSNER, CHIEF RESEARCH AND DEVELOPMENT OFFICER, VETERANS HEALTH ADMINISTRATION

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for the opportunity to testify.

The first bill I would like to discuss is H.R. 862. This bill would add Type 2 diabetes to the list of diseases presumed to be service connected in veterans exposed to certain herbicide agents. In view of the final rule recently issued by VA concerning this subject, we believe this bill is unnecessary.

On May 8th, 2001, we published, in the Federal Register, a final rule which does add Type 2 diabetes to the regulatory list of diseases that VA presumes to be service connected in veterans exposed to certain herbicide agents in service. This final rule was effective yesterday. We see no need for legislative action ratifying this regulatory determination.

To talk about the Gulf War Undiagnosed Illness Act of 2001, H.R. 1406, which concerns compensation for certain Gulf War veterans, we cannot support enactment of Section 2 of this bill, but we do support the enactment of Section 3.

Section 2 would include fibromyalgia, chronic fatigue syndrome, or any ill-defined illnesses among the illnesses for which a presumption of service connection may be established for resulting chronic disability suffered by Gulf War veterans.

With regard to fibromyalgia and chronic fatigue syndrome, under current law, service connection may be accomplished on a direct basis for disability resulting from either of these conditions. With

regard to the other conditions that would be added by section 2, the descriptions of these conditions are very vague and would result in great uncertainty regarding proper implementation.

The Department is pursuing multiple research initiatives intended to identify diseases or conditions that may be associated with service in the Gulf. The results of this research will provide a scientific foundation for decisions on possible presumptive service connection of diseases or conditions found in veterans of the Gulf War.

Section 3 of the bill would authorizes the Secretary to decide that medical information derived directly or indirectly from the participation in a medical research project by Gulf War veteran who was in receipt of disability compensation under either section 1117 or 1118 of title 38 may not be used in adjudicating the veterans' entitlement to compensation. Veterans who suffer from undiagnosed illnesses should not be discouraged from participation in significant research projects that may result in a better understanding of their illnesses.

In addition, if significant numbers of Gulf War veterans who suffer from undiagnosed illnesses refuse to participate in such research projects out of fear that their entitlement to compensation may be adversely affected, the results of such studies may be rendered unreliable. Accordingly, Mr. Chairman, we support this provision.

I would like to discuss H.R. 1435, and 1746 together, because we believe that it addresses the same basic issue. Both bills deal with VA having a centralized toll-free telephone number that enables veterans Nationwide to receive complete and accurate information.

Although we fully support the goals of these bills, we are unable to support H.R. 1435 and believe we are already in substantial compliance with the implied mandate of H.R. 1746.

H.R. 1435 authorizes the Secretary to award a grant to a private, nonprofit entity to develop and operate a national toll-free telephone hotline to provide information and assistance to veterans and their families.

H.R. 1746 would require VA to provide a single toll-free phone number to enable the public to have access to veterans' benefits counselors.

We would first note, Mr. Chairman, that the Veterans Benefits Administration has had a national toll-free number since 1993. That number is listed in the blue pages of the telephone book. It is under the heading Benefits Information throughout America.

While we believe our efforts substantially comply with the intent of H.R. 1746, we recognize the limitations to the current phone service and realize there is much we can do. We do believe the VA should have the flexibility to use the latest technologies in a way that will be of greatest assistance to veterans and other people who come to us for help, and we would be pleased to meet with your staff and discuss VA telecommunications concerns and initiatives.

VA supports the enactment of H.R. 2359 if the bill's cost can be accommodated within the budget limits agreed to by the President and Congress.

Section 1 would authorize the payment of unclaimed NSLI and USGLI insurance proceeds to an alternate beneficiary. VA supports enactment of section 1 of this bill.

Section 2 would extend by 4 years the sunset of the VA's direct loan program for Native American veterans living on trust lands. VA strongly supports this program and favors enactment of this provision.

H.R. 2359 would also make two changes to the current law.

First, the bill would permit VA to make loans to members of a Native American tribe that has entered into an MOU with another Federal agency, as just described in Congressman Udall's testimony. It would also modify the requirements concerning assumability of VA loans and how we have to notify folks of that. VA supports both of these changes.

We recommend also that Section 2 of H.R. 2359 be further amended to repeal a requirement that VA outstation, on a part-time basis, Loan Guaranty specialists at tribal facilities if requested to do so by a tribe. We believe we can provide all necessary services to Native American veterans seeking VA housing loans without outstationing employees.

Section 3 would eliminate the requirement for appellants to furnish the Secretary of Veterans' Affairs with a copy of the notice of appeal filed with the U.S. Court of Appeals for Veterans Claims. We support enactment of Section 3 of this bill.

Regarding H.R. 1929, it would also extend the sunset for the Native American veteran housing loan program and amend the requirements on MOUs. However, it does not address the loan assumption notice. Accordingly, we prefer the language in H.R. 2359.

Finally, Mr. Chairman, H.R. 2361, the Veterans' Compensation Cost-of-Living Adjustment (COLA) Act of 2001, would authorize a COLA for fiscal year 2002 in both dependency and indemnity compensation and disability compensation. The rate of increase would be the same as the COLA that would be provided under current law to veterans' pension and Social Security recipients, currently estimated at 2.5 percent.

We estimate that enactment of this section would cost $376 million during fiscal year 2002; $7.1 billion over fiscal years 2002 through 2006; and $28.5 billion over the periods 2002 to 2011. Although this section is subject to the PAYGO requirement of the Omnibus Budget Reconciliation Act of 1990, the PAYGO effect would be zero because OBRA requires that the full compensation COLA be assumed in the baseline. We believe this proposed COLA is necessary and appropriate in order to protect the benefits of affected veterans and their survivors from the eroding effects of inflation.

Mr. Chairman, that concludes my statement. Dr. Feussner and I would be pleased to respond to any questions that you or the members of the committee might have.

Mr. SIMPSON. Thank you, Mr. Thompson.

[The prepared statement of Mr. Thompson appears on p. 110.]

Mr. SIMPSON. According to a 1999 survey of veterans satisfactions with the VA compensation and pension claims process, only 26.8 percent of the veterans verified that the VA told them about other benefits for which they might be eligible. Has this number

changed since 1999, and what is the VA doing to ensure that the other 73.2 percent of veterans are being told about the other benefits that they might be eligible to receive?

Mr. THOMPSON. I don't know how the number has changed since 1999, but I can tell you what we are doing to try to improve that. We have a number of initiatives designed with the intention of trying to provide more complete information to veterans. I will give as an example, in 1997, a veteran calling VA, calling the 800 number, had a better than one-in-two chance of getting a busy signal the first time he or she called. That number now is less than 2 percent of the time that they get the busy signal on the first call.

We have put in place extensive training for employees. We have built information systems that will give them more information in the computer database, with the intention of providing that information.

Having said all that, we still have a long way to go. We still have a lot of work to do, both in terms of training and building the support systems to provide better information to veterans and we recognize that.

I think our major point would be that we have moved quite a bit in the last several years, and we continue to try to push that to make the performance better so veterans, when they call us, have a reasonable—not a reasonable, but an excellent chance of getting all the help they need the first time they call.

Mr. SIMPSON. You mentioned in your testimony on the Native Americans Veterans Home Loan Act that you are supportive of the legislation. You have concerns about requiring the stationing of an employee on the tribe if requested by the tribe.

Mr. THOMPSON. Correct.

Mr. SIMPSON. How do you intend to address that issue and make that information and services available to Native Americans if this were to become law, and how do we increase that knowledge on Native American tribes?

It has been my experience that going in there once a month and explaining this is not the best way to tell the Native Americans what is available to them and educate them. In fact, you have to be there in person on a daily basis to address this. So how does the Administration plan to address it?

Mr. THOMPSON. Let me discuss why we propose changing the law to not require the outbasing. We have consolidated, or centralized, our loan processing. We used to have 46 loan centers. We are down to nine today, and the outbasing issue, because of the resource issues, has become much more problematic. You are correct that the information available to Native Americans living on reservations and on tribal lands is scant compared to what is available throughout the rest of the society.

We have done extensive outreach efforts. We have sent people on an temporary basis, and we certainly send them any time requested. We made a video, for example, on the Native American housing program. We actually worked with the tribes in the construction and have a number of Native Americans on the video itself trying to promote the participation in the program.

But I think the issue of both getting information out and dealing with the issue of building on trust lands continues to vex us. The

program is not as large as—or has as many participants as we would like to see. So we absolutely support the legislation and are absolutely open to any other alternatives that would allow us to make this a more successful program than it is.

Mr. SIMPSON. I appreciate that.

On the Type 2 diabetes, you believe it is unnecessary. You don't have any problem with codifying it, though, do you?

Mr. THOMPSON. It would have no direct impact, but I would suggest this. The Congress created a process for us to add presumptive conditions based on exposure to Agent Orange and other herbicides. The National Academy of Science's Institute of Medicine does a review every 2 years. They send us a list of diseases, and they categorize them as to whether it is very likely to be associated with dioxin exposure or totally unlikely and points in between, and then the Secretary uses that information to add diseases to the list of presumptive conditions.

We have added other diseases in the past, including prostate cancer and lung cancer. I would think that that process works well, and we would urge that it be kept in place.

Mr. SIMPSON. So the Congress has effectively given the Administration the authority to make policy relative to making presumptive decisions on diseases, whether it is in the Agent Orange area or with the Gulf War veterans?

Mr. THOMPSON. We believe that to be correct. In fact, the effective date of presumptive regulations on Type 2 diabetes was yesterday, and we have 30,000 claims that have been filed in anticipation of the passage of the regulation. So we think there is an effective forum for dealing with these issues.

Mr. SIMPSON. Thank you. Mr. Reyes.

Mr. REYES. Well, thank you, Mr. Chairman.

Just to clear the record, lung cancer is part of the statute, right? Not interpreted by——

Mr. THOMPSON. Yes. You are correct.

Mr. REYES. There are a couple of things that I want to ask you about.

First, welcome. Thank you very much for the work that you do. I appreciate you coming by my office and sharing some of the concerns that we both have about better outreach, better service for our veterans. So I appreciate that, and thanks for being here; and you, too, Doctor, as well.

First, when we talk about the issue of outreach, it is my understanding that action on 15 pending home loans was substantially delayed earlier this year because outreach funds were not made available to the Honolulu office during the first months of this fiscal year; and I am curious to know on what basis has VA determined that such loans can be processed without the outreach provisions contained in the current law?

Mr. THOMPSON. I apologize. I am unfamiliar with that particular issue. I didn't realize that there were 15 loans being held up, but, if you would, I could get back and give you a more detailed answer.

Mr. REYES. Please provide this information so you can answer it for the record.

(The attachment follows:)

Regarding Rep. Reyes' inquiry regarding 15 loans for Native Americans in the South Pacific):

Our Honolulu Office has informed us that earlier this year inspections for approximately 10–15 Native American Veteran Direct Home Loans were delayed pending the approval of travel funds for field personnel to go to American Samoa to conduct compliance inspections on the construction of new homes. These travel funds were approved and between March and May of this year the Honolulu office issued 12 Certificates of Reasonable Value for loans in American Samoa. Our Honolulu Regional Office informs us that there are approximately 69 more loans in the pipeline in Samoa at present for which funds will be available.

Mr. REYES. But the point—there are several points that I want to make.

First and foremost, when we talk about outreach and when we talk about the provision that the VA has gone on record as opposing in the legislation that Mr. Udall is introducing, we all know that in reservations there are no building inspectors, there are no permits. So it becomes vital and critical that these outreach efforts by the VA are conducted so that they can insure that the homes that are being built and the progress is being monitored and making sure that everything is complied with in the construction of these homes.

It is not—at least it has been my experience, it is not that anyone expects or is getting a weekly visit by these outreach personnel. In some cases, they go several months without going. But the point is that there is a system in place that makes sure that there is 1,500 PSI concrete or whatever that figure is, that it is number two or get better grade two-by-fours, that it is 30 pound felt roofing et cetera, et cetera. So that unscrupulous people aren't going in there, getting paid for one kind of construction process, while giving very shoddy—taking advantage of a population, as I said earlier—and I hope you heard—that is not as well versed and educated and understands their rights. So it is inherent upon the VA to become that advocate for those veterans so that they don't get, again, shafted in this process.

And this goes to the crux of the question I am asking. There were 15 pending home loans that were sitting in abeyance because outreach funds were not provided to the office in Hawaii. That is an example of why at least I am concerned that you would make a recommendation to eliminate the outreach provisions of Congressman Udall's legislation.

Mr. THOMPSON. Well, we weren't recommending that outreach be eliminated. We are recommending the permanent stationing of VA employees for that purpose be eliminated.

As I said, I am unfamiliar with that particular issue, and we will get back to you in specific detail, but I can't imagine that outreach funds themselves would hold up loans. So my guess is there was not an employee available to go and do an inspection. But that is different from outreach. I mean, that is not outreach, per se, which is what we do in the home loan program, whether it is a house being built on tribal lands or a home being constructed in a subdivision in Alexandria. So I will run that down, Congressman. I really don't have an answer for you on that.

Mr. REYES. Well, then I would appreciate you getting me that information, because, frankly speaking, it won't be the first time that the testimony here does not jibe with what actually is happening

out in the many different VA offices. So it is important for that—again, for that provision.

The other part that I will take issue with you is, you know, if—we have got to have the flexibility, I think, that if a tribe has a need, a specific need, for a specific service from the VA and it could be, if not stationing somebody permanently, at least making that individual available on a more regular basis—I mean, there are a lot of scenarios; and I am glad that the chairman is well versed on the issue of the Native American issues, because, again, we are talking about an agency that needs to be advocating instead of—doing more instead of doing less for our veterans.

One other thing very quickly while I have—still have a few minutes—or a few seconds. When we talk about direct basis, it means that it was diagnosed or treated in the service so that the veteran can prove that there was a nexus to that diagnosis.

Mr. THOMPSON. Correct.

Mr. REYES. But, Mr. Secretary, wouldn't you agree that one of the biggest problems we have in today's veteran population is the fact that post Gulf War, where who knows what was utilized against our troops, whether it be chemical, biological or some other unknown substance, one of the biggest problems and one of the biggest issues is that we don't know how quickly some of these elements work? We don't—it is not traditional combat-type impact or results on our veterans. So there has got to be some latitude in there to—and I would hope that it would go in the favor of the veteran, so that if a veteran is coming up with some symptom—and really, Mr. Chairman, as you know, it goes back beyond the Gulf War. Because we started seeing the—and some of my colleagues on this committee fought to have the inclusion of Agent Orange and the impact that it had on the whole generation of veterans.

So my point here is, again, the Veterans Administration should be an advocate. It is like in baseball. The tie goes to the runner—the tie has to go to our veterans out there. They are the ones who put their butts on the line. They are the ones who are suffering with the consequences of defending our country in parts of world where we just don't realize, we just don't know what they went up against. We don't know if it was chemical, biological, or maybe some other impact that is yet to be determined.

I mean, I can remember looking at stories covered by CNN and all the major networks where there were scorpions, there were snakes, there were all kinds of different elements that our troops went up against.

So, again, in closing, I would hope that the tie goes to the veteran and not to the VA. Thank you, Mr. Chairman.

Mr. SIMPSON. Thank you. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. It is good to be with you. This is my second meeting on this subcommittee, and I am a temporary appointment here.

I have to say I am a little bit gun-shy. My first meeting I started asking questions about the GI Bill of Rights and somehow ended up canceling full committee markup and the bill went to the floor, bypassed the full committee. There was a lot of anger.

I just want to ask some questions, Mr. Secretary. Would you help me understand, if you would, from your perspective, who—I am

talking now about H.R. 1406. What is the problem, as you see it, that has motivated all the VSOs and the members that are on this bill? What is the problem that they are trying to get at, as you see it?

Mr. THOMPSON. Well, from listening to the testimony in this and other hearings, I think that it was mentioned in the first panel. I think the belief is that we call these decisions too close; that we're too tight, and that, as a result, Gulf War veterans are not being well served by the disability compensation program. That is the 75 percent denial rate that——

Mr. SNYDER. Correct.

Mr. THOMPSON. There are some other factors I think would need to be considered in that. Of the 74 percent who were denied for undiagnosed illnesses, 28 plus percent are granted some other type of compensation and/or pension benefit. We either find another service-connected disability or we find entitlement to pension.

If you look at the cohort of Gulf War veterans, the number of Gulf War veterans who receive compensation is higher than any other period of war in the 20th century; and the number of disabilities each veteran is being compensated for is also higher than veterans of any war in the 20th century. The question is, how far past medicine and science do you go to add service-connected disabilities? Because we don't have the data—or we have not seen the data—that would suggest that you should add more presumptive conditions for Gulf War veterans.

Mr. SNYDER. I don't think I have seen those numbers for the different wars. If you could provide that.

Mr. THOMPSON. We could.

(The attachment follows:)

Rep. Snyder asked about Gulf War Veteran Statistics

"Gulf War are the most highly compensated group"

Current statistics show that 32 percent of Gulf War veterans are currently receiving compensation compared to 28 percent of Vietnam veterans and 3 percent of W.W. II veterans.

Gulf War:	
In receipt of comp	354,000
divided by the total in-theatre	1.1 mil
	= 32%
Vietnam:	
In receipt of comp	744,000
In country	2.7 mil
	= 28%
For W.W. II,	
In receipt of comp	478,000
In Service	17 mil
(since we don't have anything else)	= 3%

Source: RCS 20–0221, GWVIS.

Mr. SNYDER. I want to get at some of the language in H.R. 1406. Now, if I heard your testimony, what you are saying is that if someone is diagnosed with fibromyalgia or chronic fatigue syndrome, they could already be compensated for it. Is that what you are saying?

Mr. THOMPSON. That is correct.

Mr. SNYDER. Now, under the statute, are those two entities already in your list of presumptive illnesses?

Mr. THOMPSON. They are not presumptive illnesses, but they are in our schedule rating disabilities of diseases that can be service connected on a direct basis. In other words, we can make the direct connection between your military service and the disease.

Mr. SNYDER. And I assume you have done that with those two entities?

Mr. THOMPSON. We have.

Mr. SNYDER. Then the third listed here is a chronic multi-symptom illness. Now, the first one that came to my mind was rheumatoid arthritis. I assume that would be chronic multi-symptom illness. Are there other—I assume that any chronic multi-symptom illness you could already do compensation for and find a service connection with, is that correct?

Mr. THOMPSON. I am going to ask Dr. Feussner to jump in here, because I am about to get over my medical head on some of these things. I'll read you the list that we direct service connect and——

Mr. SNYDER. Okay.

Mr. THOMPSON. Fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, ALS, autoimmune disorders, lupus, HIV and undiagnosed illnesses would all be under the categories of——

Mr. SNYDER. I assume—like rheumatoid arthritis, I assume would be in there under autoimmune. Would you include that or——

Mr. THOMPSON. I am not sure. I would believe so, but——

Mr. SNYDER. Dr. Feussner?

Dr. FEUSSNER. Yes, Dr. Snyder. I think that chronic multi-symptom illnesses that have explicit diagnoses like rheumatoid arthritis could be dealt with in a pretty clear way. I think when we talk about chronic multi-symptom illness we are talking about illnesses that don't have a precise diagnosis, that are characterized more generally, like chronic fatigue syndrome with presenting symptoms of fatiguing illnesses, musculoskeletal pain and neurocognitive defects.

Mr. SNYDER. Now, are there other entities other than what we have talked about, other named chronic multi-symptom illness other than the ones that are listed in the statute or that were read in that list?

Mr. THOMPSON. We would need to get back to you on that. I am not sure.

(The attachment follows:)

Rep. Snyder asked if there are entities other than what we have talked about, other named chronic multi-symptom illnesses other than the ones that are listed in the statute or that were read in that list.

Illnesses mentioned at the hearing were:

- Rheumatoid arthritis
- Fibromyalgia
- ALS
- Chronic fatigue syndrome
- Autoimmune disorders
- Lupus
- Irritable bowel syndrome
- HIV
- Undiagnosed illnesses

What are some other chronic multi-symptom illnesses?

There are many other illnesses that could be considered chronic multi-symptom illnesses. These include:

- Sarcoidosis
- Leukemia
- Multiple sclerosis
- Nutritional deficiencies
- Arteriosclerosis
- Cancer of all types
- Other conditions too numerous to list

What is a chronic multi-symptom illness?

There is confusion about the meaning of the term "chronic multi-symptom illness". It has both a generic meaning and, more recently, has been given a more specific meaning that refers to the collection of chronic symptoms found in Gulf War veterans.

- In the generic sense, the term could encompass almost any chronic disease, because very few chronic diseases or conditions have only one or two symptoms.
- In the more specific sense, the term was used for ill-defined illnesses of Gulf War veterans in a CDC study called "Chronic multisymptom illness affecting Air Force veterans of the Gulf War" (Fukuda K, Nisenbaum R, Stewart G, et al. JAMA. 1998;280:981–988). A case of chronic multisymptom illness was defined based on reporting one or more chronic symptoms from at least 2 of 3 categories (fatigue, mood-cognition and musculoskeletal). The study found that among currently active members of 4 Air Force populations, a chronic multisymptom condition was significantly associated with deployment to the GW. The condition was not associated with specific GW exposures and also affected nondeployed personnel.

The more specific meaning of the term, as defined by CDC, has since been used in the medical literature and by other Gulf War researchers. The more specific meaning is presumably also the meaning in the proposed legislation. A reference to this meaning in the legislative proposal would more clearly indicate the intent of the legislation.

Mr. SNYDER. This phrase "other ill-defined illness," in your testimony, Mr. Secretary, you said that this statute was vague. Is that the area that you are referring to when it refers to—is ill-defined illness—is ill-defined a term of art or is this the first time that that phrase appears in the statute and in your regulations, ill-defined illness?

Mr. THOMPSON. I am not sure if it is in an earlier statute. It is part of H.R. 1406, but I am not sure if it appeared prior to that.

Mr. SNYDER. I am not sure. The——

Mr. REYES. Just for point of information, it is in the preamble of the original statute, according to counsel.

Mr. SNYDER. The preamble. Is it a defined term?

Ms. MCCARTHY. I believe the clarification of the general counsel opinion, it was used in the preamble to the statute. But then when we use the term in the actual body of the statute, it was just listed as undiagnosed, as opposed to diagnosed or ill-defined.

Mr. SNYDER. Because that is what I am trying to understand. Because now we have got the phrase "undiagnosed illness" and then we also now are going to have the phrase "ill-defined illness," and I am just trying to understand if that is going to be a problem for the folks who are trying to sort through this. But I am just asking questions. That is all.

I wanted to ask about the phones, Mr. Thompson. Would you respond to the concern of Congresswoman Capps in her written statement that was read by Mr. Reyes about emergencies, weekend and evenings and those kinds of things? Are your—is your phones inadequately staffed? What is the problem? How do you respond to those criticisms?

Mr. THOMPSON. I think that the general sense is that in the legislative proposals we have seen, they are trying to lump too many things into a single phone number. That is where the difficulties begin.

As you know, Dr. Snyder, these are enormously complex programs. They cover a wide range of areas. I mean, there are more than a thousand programs at the State level for veterans, speaking of what VA does, whether it is health care or disabilities or home loans or vocational rehabilitation, life insurance.

Our issue is, and I think our philosophy is, is that the best thing we can do for someone who needs help from us is to put them in touch with somebody who can handle their issues specifically. Now, we do get a number of general calls, but our approach has been to try to segment out calls. So if it is on a home loan, it goes to someone who has a background in home loan issues. If it is on disability compensation, if it is health care, they probably want to talk not just to somebody who knows health care but somebody who is affiliated with the hospital or the clinic that is near his or her house that has some information about how long it might take to get employment, those kind of things.

So I think that, while we do agree with the intention of the bills, that providing service and trying to give veterans or their family members all the information they need or they desire is our goal as well, the solution is more complex than trying to get a single phone number that would handle the myriad of issues that could arise. That really is a lot more complicated.

I think we have a fair amount of experience. I mean, we handle between 15 and 18 million phone calls a year. We have some idea of how this works. So I think the intentions of the bill are good. The 24 by 7 service is something the Secretary has asked us to look at specifically, and to see what it would take to man a phone center that period of time, so we are undergoing that. Again, our objections aren't to the legislation or the intent of the legislation as much as to what the best solution would be for this.

Mr. SNYDER. I am sorry, Mr. Chairman. I was on recess too long. I neglected to pay attention to the lighting system. But I will get better. Thank you.

Mr. SIMPSON. That is okay. I appreciate it.

I appreciate your testimony today, Mr. Thompson; and I look forward to working with you and to address these concerns that our veterans have.

Mr. REYES. Can I just ask one additional question?

Mr. SIMPSON. Sure.

Mr. REYES. It deals with this phone system. You said there were, I think, 15 million or 18 million a year, calls that were—is that correct?

Mr. THOMPSON. That is correct.

Mr. REYES. Do you keep statistics on things like the busiest time, how long people wait?

Mr. THOMPSON. Absolutely.

Mr. REYES. Because one of the issues here is it should not be a situation where veterans call when it is convenient for the Veterans Administration. It is when they need to be calling because they have got some issue. And when we talk about veterans that par-

ticularly are homeless, they are hungry, they are hurt, they have got some mental anguish and those kind of things, it is not between 8 and 5 Monday through Friday. In fact, based on anecdotal information that I've seen, it is usually the weekends and after hours that depression and those kinds of things kick in.

So I would like two things. One, I would like statistics that you might have on the 800 number by the VA; and, number two, I would like you to comment on the issue of being available when the veterans need you, versus when it is convenient for the Veterans Administration.

Mr. THOMPSON. Well, I think we are in agreement. We can certainly provide the information. We have a fair amount of information on phone service.

(The attachment follows:)

On page 20, Rep. Snyder asked if VBA's phones are inadequately staffed, what criticisms we have received and how we would respond to them.

The majority of our telephone calls are routed to our Veterans Service Centers, which also process compensation and pension claims. The statistics for these calls reflect a blocked call rate of 3 percent, which supports our position that we have sufficient staff to answer these calls.

However, for the Education Regional Processing Offices (RPO), the blocked call rate for this fiscal year is 48 percent. But, we believe that we will see significant improvement by the end of this fiscal year since we will have added 150 FTEE by then. We have already seen a dramatic improvement in the RPOs' blocked call rate which was at 65 percent in October 2000 and had fallen to 26 percent in June 2001.

We have heard criticism to include: our phone free being too long and complex; the wait time being too long before a real person answers the phone; and our telephone hours of operation not convenient for the callers. This year we had an independent contractor evaluate our National Automated Response System (NARS). Based on recommendations made by the contractor, we are making substantive design and script changes to make NARS user-friendlier. Beginning in December 2001, we plan to have a 5-digit case call routing that will allow callers to dial their case team directly from our toll-free number without going through the phone tree. We also have plans to extend and standardize our telephone hours of operation to meet our callers' needs.

In addition, we are deploying Virtual Information Centers (VIC) across the country by Service Delivery Network (SDN), which will further improve our utilization of resources on the telephones and will greatly assist us in extending our hours of operation on a regional basis. A VIC pools staffing from multiple regional offices to answer the same group of calls, thus providing more efficient phone coverage and virtually eliminating blocked and abandoned call rate. VICs also provide the telecommunications architecture for our future multi-channel e-gov initiatives making VBA more accessible to veterans through whatever means of communication they choose and whenever they want to reach us.

Rep. Reyes asked whether VBA "keeps statistics on things like busiest time, and how long people wait.".

Our busiest time of the day for most regional offices is usually between 10 a.m. and 11:00 a.m. and between 1:00 p.m. and 3:00 p.m. local time. 97 percent of our calls nationally are received between 8:00 a.m. and 8:00 p.m. (EST). Approximately 92 percent of calls to regional offices are answered with 3 minutes. (It is important to note that this figure is derived from local telephone reports. Some offices are not able to accurately report this data due to the limitations to their telephone equipment.)

Rep. Reyes raised the issue of VA "being available when the veterans need us, versus when it is convenient for the VA."

As mentioned above, we have taken steps to improve the quality of service we provide our callers. VBA's core of telephone business pertains to benefits issues, which does not require 24-hour accessibility. While VBA does receive some calls from veterans in crisis most issues pertaining to callers with mental anguish and those in

need of immediate assistance due to health and safety matters are best dealt with by VHA or Vet Centers who are trained to provide such services.

Mr. THOMPSON. I agree with what you said about being available for veterans when they need it. As I mentioned to Congressman Snyder, the Secretary has charged us with looking at 24 by 7 service, having someone that can answer the phone. The question is, what kind of work can they do at 3:00 in the morning if it involves a disability compensation claim? How much information can be provided to them on an on-line basis? Because, right now, we are hamstrung, for example, by having the need to get the veteran's claims folder, to do the research and answer their questions they are asking.

Those are some of the limitations and some of the things we are trying to deal with.

There is no question, if we had all the data available in an on-line fashion, we would have a tremendous amount of flexibility. You can provide the service.

But I can tell you the Secretary is committed to this. He absolutely wants us to be available when veterans need to speak to us. We are doing everything that we can think of in terms of trying to improve this service. I don't want anybody to misunderstand and think that I am sitting here saying that we give great service all the time. That is not the case. We realize we have a lot of work to do, and we are committed to doing that.

Mr. REYES. Thank you.

Mr. SIMPSON. Thank you.

Again, I appreciate your testimony and look forward to working with you on these issues.

Our third panel is made up of representatives from several veterans' service organizations. Mr. Joseph Violante is with the Disabled American Veterans. Mr. James Fischl is with The American Legion, and Mr. Sidney Daniels represents the Veterans of Foreign Wars. Welcome, gentlemen, to the committee today.

STATEMENTS OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JAMES R. FISCHL, DIRECTOR OF VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND SIDNEY DANIELS, DEPUTY DIRECTOR OF NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. SIMPSON. Mr. Fischl, we will start with you.

STATEMENT OF JAMES R. FISCHL

Mr. FISCHL. Thank you, Mr. Chairman and members of the committee. The American Legion appreciates the opportunity to provide testimony on the key veterans' legislation being considered by this subcommittee.

H.R. 862 would amend title 38 to add diabetes to the list of disabilities for which presumptive service connection may be granted in the case of veterans who served in the Republic of Vietnam.

In the year 2000, the VA requested the Institute of Medicine and the National Academy of Science to review the scientific literature

to determine whether there was a relationship between dioxin exposure and an increased incidence of Type 2 diabetes. The IOM found "limited suggestive evidence" of a link between such herbicide exposure and Type 2 diabetes. The Department of Veterans Affairs subsequently promulgated regulations providing for presumptive service connection in claims by veterans who served in the Republic of Vietnam during the Vietnam era. These regulations became effective yesterday, July 9, 2001.

Mr. Chairman, the American Legion commends the VA for its positive response to the needs of thousands of veterans who served in Vietnam and who are now suffering from diabetes.

The fact that the VA has regulations in place which allow veterans with this disability to be compensated raises the question, is legislative action really necessary? We believe it is. In our view, the interests of veterans seeking service connection for diabetes based on exposure to Agent Orange will be better served by having the presumption established by statute rather than by regulation. While the current administration is supportive of this regulatory change, there is nothing to prevent a future administration from reneging on the commitment. By way of contrast, the public nature of the legislative process makes it much more difficult for any administration to make arbitrary or drastic changes in the veterans' benefits program. The American Legion supports H.R. 862.

H.R. 1406, the Gulf War Undiagnosed Illness Act, would improve presumptive compensation benefits for veterans with ill-defined conditions resulting from service in the Persian Gulf.

In 1994, legislation in the form of Public Law 103–446 was enacted to insure compensation for Gulf War veterans suffering from unexplained conditions commonly referred to as Gulf War veterans' illness. Yet most Gulf War veterans who have filed a claim for undiagnosed illness compensation have been denied service connection. A 75 percent denial rate is the current reality for sick Gulf War veterans trying to establish service connection.

Mr. Chairman, there are many uncertainties and unanswered questions that encompass the multiple unexplained physical symptoms experienced by many Gulf War veterans. To date, research into the possible causes and long-term health effects from their exposure to the multitude of toxic agents and other hazards to which Gulf War veterans were exposed during the war have been mostly inconclusive. This is why it is imperative that the law allowing compensation for such illnesses recognize the uncertainty and limitations in Gulf War research in order to establish a fair and just means of compensation for ill Gulf War veterans.

Clarifying the definition of "undiagnosed" for VA purposes under the law to include poorly defined conditions such as chronic fatigue syndrome, fibromyalgia and other such conditions is necessary in order to recognize both the original intent of Congress and the complexities involved with Gulf War-related research and treatment. Doing so would serve to correct the deficiencies in the current law and help to insure that ill Gulf War veterans receive the compensation to which they are entitled.

The American Legion believes H.R. 1406 is a good first step in correcting these deficiencies.

The current presumptive period for undiagnosed illness claims is set to expire at the end of this year. However, Gulf War-related research to date, as highlighted by a September, 2000, Institute of Medicine report on the long-term health effects of exposure during the Gulf War, has been inconclusive. Research is ongoing, and the IOM is scheduled to release several additional reports on long-term health effects in the future. Therefore, due to the inconclusive nature of Gulf War research and the resulting uncertainties, it would be unconscionable to allow the presumptive period to expire at the end of this year. The nature of the Gulf War veterans' illnesses and limitations and problems with Gulf War research, as cited by the IOM, warrant, at the very least, a 10-year extension of the presumptive period.

Representative Donald Manzullo has introduced H.R. 612, the Persian Gulf War Illness Compensation Act. In addition to clarifying the definition of undiagnosed illnesses considered under Persian Gulf War illness, H.R. 612 will extend the presumptive period through December 31, 2011. The American Legion supports both H.R. 1406 and H.R. 612.

H.R. 1435, the Veterans' Emergency Telephone Service Act, would authorize the Secretary of Veterans' Affairs to award grants of $2 million for fiscal year 2002 and fiscal year 2003 for the establishment of a national toll-free hotline to provide information and assistance to veterans.

H.R. 1746 would require the VA to establish a single "1–800" telephone number in order to provide public access to veterans' benefits counselors and to insure that such counselors have available to them information on all Federal and State benefit programs.

As Mr. Thompson said, that is a tall order; and we find, while that is a noble cause, we don't really feel that that could work. Basically, we feel that the VA has a system in place and, if that system isn't working, are we sending the right message by saying we will find an alternate route. We will get somebody else to do the work. We will let the private sector do it.

We feel very strongly that the VA can. They are mandated by law to do this, and they should be able to do it. And if they are having problems, well, let's address those issues and not bring in a private organization to do that. We just don't feel that would work. We feel it would be basically duplicative. And lowering the expectations by acknowledging that the current 800 number doesn't work sends the wrong message.

H.R. 1929 would amend section 3761 of title 38 to extend the Native American veterans housing loan program, which currently expires on December 31. We support that.

H.R. 2359 would amend title 38 to authorize the payment of National Service Life Insurance and United States Government Life Insurance proceeds to the alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veterans' housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans' Affairs a copy of a Notice of Appeal to the Court of Appeals for Veterans' Claims. We support all of those provisions.

In our view, the proposed elimination of the requirement for an appellant to notify VA of the filing of a Notice of Appeal would make the Court's appeal procedures less confusing and burdensome, and this would not alter the Court's current administrative procedure. The American Legion, therefore, is not opposed to this proposal.

We also support the Veterans' Compensation Cost-of-Living Adjustment Act.

Mr. Chairman, that completes my testimony. Again, I thank you for allowing the American Legion to provide comments on these important issues. The American Legion looks forward to working with the members of this committee to improve the lives of all of America's veterans.

[The prepared statement of Mr. Fischl appears on p. 121.]

Mr. SIMPSON. Thank you, Mr. Fischl. Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you.

Mr. Chairman and members of the committee, on behalf of the more than one million members of the Disabled American Veterans and its auxiliary, I express my appreciation for your decision to give hearing consideration to the legislation contained on today's agenda.

Mr. Chairman, I congratulate you on your recent appointment to chairman of this subcommittee. I look forward to working with you and your subcommittee in the future to ensure that our Nation's service-connected disabled veterans, their families and survivors are properly cared for and made a national priority.

Our written testimony contained our views on all the pending legislation. I will briefly comment on a few of the bills.

We support H.R. 862. It merely codifies the Secretary's action to add diabetes mellitus Type 2 to the presumptive list. As my colleague pointed out, it is much easier to change a regulation than it is a statute; and, therefore, we support codification.

H.R. 1406 would improve presumptive service connection compensation benefits for veterans with ill-defined illnesses resulting from the Persian Gulf War. This measure would expand the list of disabilities recognized as disabilities resulting from service in the Persian Gulf War. As with H.R. 612, the DAV supports these measures.

There are a number of problems, as Dr. Snyder pointed out, and while some of the disabilities listed in these bills can be service connected on a direct basis, the problem is on a direct basis a veteran must have proof of a cause-and-effect relationship after service. With a presumption, the government assumes that there is a cause-and-effect relationship. So we support redefining the definition and expanding the list. Too many Persian Gulf veterans are currently being denied benefits.

We also note that the presumptive period is due to expire; and, Mr. Reyes, we appreciate your position on that. However, we still have concerns that many veterans, some of whom are probably still serving on active military duty, don't come forward with their problems.

I spent 3 years in the Marine Corps; and I learned early on that if you went to sick bay it really didn't help your ability to advance in the military. So we have some concerns about cutting off that date or even making it just 10 years beyond service in the Gulf.

H.R. 1435 would authorize the Secretary to award grants to provide for a national toll-free hotline to provide information and assistance to veterans. We are opposed to this legislation as it is currently written. This measure attempts to take away an intrinsical part of the VA's mission of service to veterans and their families.

We conducted a survey in March, and we were surprised by the results of that phone survey. We asked our supervisory NSO across the country in 69 offices to call the VA's 800 number to ask a question on the Agent Orange hotline which had just recently been published by VA and to track the time it took them or the number of calls it took them to get through and how long they were on the phone before they received an answer. Surprisingly, the vast majority of our people were able to get through the first time. Very few experienced a busy signal.

It was also surprising that it took less than 5 minutes, as an average, to get a proper response to their questions. In some cases, our people were put on hold while the phone number was obtained. In a few cases, the information that was provided was incorrect, but we believe that it shows that the VA's system is working.

If the subcommittee believes the VA is not adequately meeting the needs of veterans or other VA claimants in providing this information, then we should hold the VA accountable. If the subcommittee also believes that this information should be available 24 hours a day, then let's provide VA the resources to man those phone lines.

H.R. 2359 would authorize the payment of National Service Life Insurance and the United States Government Life Insurance proceeds to an alternative beneficiary when the primary beneficiary cannot be identified.

I am a holder of a VA policy. I receive an annual statement on my policy, and I also received recently something from the VA asking me to update my beneficiaries, providing their Social Security numbers and the like. I don't see why VA can't continue to do that on an annual basis when they send out those statements to insure that they have proper and correct information. In today's world, if you have a person's Social Security number, it is not too difficult to track them down.

We have some concerns about the language in this bill and also it is unclear to us what efforts the VA takes to identify these beneficiaries or the primary beneficiaries and to notify them. We feel that the 2-year window or period for filing claims is somewhat short. I don't know of any private insurance company that does that.

We have no objection to the favorable consideration of cutting off veterans from having to file a copy of their Notice of Appeal to Court of Appeals for Veterans' Claims to the Secretary. We feel that it will probably alleviate some burden on the veterans.

We support the COLA. However, Mr. Chairman, we continue to oppose rounding down of compensation increases. We urge the subcommittee and the full committee to reject recommendations to ex-

tend the sunset provisions of this deficit reduction provision or to permanently extend rounding down provisions. Veterans are the only Federal beneficiaries that I know of that have their Cost of Living Adjustments rounded down to the nearest whole dollar.

This concludes my statement, Mr. Chairman. I would be pleased to respond to any questions.

[The prepared statement of Mr. Violante appears on p. 126.]

Mr. SIMPSON. Thank you. Mr. Daniels.

STATEMENT OF SIDNEY DANIELS

Mr. DANIELS. Thank you, Mr. Chairman.

On behalf of the members the Veterans of Foreign Wars, I appreciate the opportunity to comment on the various bills under consideration today.

But I would first like to congratulate you, Mr. Chairman, on becoming chairman of the subcommittee. We look forward to your stewardship and to doing anything we can to help you here.

Mr. SIMPSON. Thank you.

Mr. DANIELS. Mr. Chairman, I would like to summarize our position on the bills under consideration today. Our statement filed earlier fully details how we feel about most of these measures.

We support H.R. 862. This legislation would add presumption of service connection for veterans who have contracted diabetes mellitus, Type 2 diabetes, as a result of exposure to certain herbicides. This legislation would provide the critically needed benefit for veterans and their dependents who have had to suffer the consequences of this devastating disease.

As part of the Agent Orange Act of 1991, the Institute of Medicine has been charged with determining the effects of Agent Orange and other herbicides on those veterans who were exposed during service. Their November 2000 report, Veterans and Agent Orange: Herbicides/Dioxin Exposure and Type 2 Diabetes, found that there is limited suggestive evidence of an association between exposure to the herbicides used in Vietnam or the containment dioxin and Type 2 diabetes.

The VFW supports H.R. 1406, the legislation to further clarify the standards used for compensation of Persian Gulf undiagnosed illness and to extend protection to veterans by allowing them to continue to receive compensation while they are participating in medical research projects without the fear of losing compensation.

We support H.R. 1435. This legislation would authorize the Secretary of VA to award grants to private nonprofit companies for the purpose of providing national toll-free hotlines to provide information and assistance to veterans. We support this measure without further comment.

With respect to H.R. 1746, we applaud the intent of this measure to establish 1–800 lines as a means to expand public access to veterans' benefits counselors at the VA. We cannot, however, support this legislation in its current format.

Among other issues, this legislation may have the unintended consequence of misdirecting scarce resources. As presently constructed, this legislation could necessitate the shifting of personnel and resources from other vital areas.

We support H.R. 1929, legislation to extend the Native American veteran housing loan pilot program. Currently, this program is set to expire at the end of 2001. This legislation would extend the program additional 4 years until 2005. In addition, Mr. Chairman, we recommend that this program be made permanent.

The VFW supports H.R. 2359, legislation that would authorize payment of insurance proceeds to an alternative beneficiary when the first beneficiary cannot be located. However, we recommend that the time limit to pay the first beneficiary designated by the insured be extended to 4 years; and if within that time period no claim has been filed the Secretary may, within 5 years, designate a person equitably entitled to the proceeds.

Finally, Mr. Chairman, the VFW supports the provisions of the Veterans' Compensation Cost-of-Living Adjustment Act of 2001. This bill increases the rates of compensation for veterans for service-connected disabilities and the rates of dependency and indemnity compensation paid to the survivors of certain disabled vets.

Although we support this legislation, we oppose the provisions of section 2(c)(3). This section requires that any amount that results in something other than a whole dollar be reduced to the lowest whole dollar amount.

It is our understanding that this practice of rounding down to the nearest whole dollar was introduced following the passage of the Omnibus Budget Reconciliation Act of 1990. While we certainly understand the importance of OBRA law in terms of assisting government managers work towards a balanced budget, it is the view of the VFW that veterans have done more than their fair share to help balance the budget and this need not continue in this day of budget surpluses. We, therefore, oppose the permanent extensions of the OBRA provision that permits rounding down compensation payments.

This concludes my statement, Mr. Chairman, on behalf of the VFW. I would be happy to take any questions.

[The prepared statement of Mr. Daniels appears on p. 131.]

Mr. SIMPSON. I thank all of you for your testimony.

Let me first ask just generally, all of you, is your opposition to establishing a toll-free number, the two pieces of legislation we have, based on allowing it to go to an outside contractor? Do you think that it would essentially be the first of a movement toward privatization of veterans' services that are offered and you think we can do it within the Veterans Administration? If we have a problem we ought to do it within VA rather than try to privatize it? Is the concern in the direction that it is going, rather than——

Mr. VIOLANTE. I think that is part of our concern, Mr. Chairman, in, number one, we are not quite sure that a nonprofit organization would be capable of doing that. And, granted, they are required to train, but, you know, it is not an easy task, even though they have to show some type of expertise in the area.

And, as you said, the other thing is we are moving towards privatization of a part of what I believe is a core element of the VA. We just don't believe that a nonprofit—candidly, I think we are sending the wrong message: If we don't believe the VA is doing an adequate job, taking it away, give it to someone else. Why try to strive to improve yourself if you are going to lose those services if

you are not successful? They should be held accountable if it is believed they are not fulfilling their obligation.

Mr. SIMPSON. It seems like it would be very difficult for a nonprofit to offer those services without having full access to the veterans' files and history and so forth, and so I agree with what you are saying.

Mr. FISCHL. Also, Mr. Chairman, I would add that it takes many years of experience till a VA employee is really conversant with the issues they need to be conversant with. How could you possibly train somebody on the outside to really give quality service? I mean, you are really asking for a monumental task there. It would be very difficult. It is difficult already for VA. They have the potential. They can do it. Can they be better? Of course they can. But I think we get what we expect, and if we don't expect quality from the VA we surely will not get it.

Mr. SIMPSON. I appreciate the fact that it takes a long time to become familiar with all the VA benefits. Just ask the new chairman of the subcommittee how long that takes!

I thank you all for your testimony. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman.

First, I was intrigued by the survey that you quoted, Mr. Violante. Do you have a copy of those stats for——

Mr. VIOLANTE. We have a very rough copy. What I can do is clean it up and present it to your staff in the very near future, giving you the breakdown on the times it took and whether the response was correct or not.

Mr. REYES. I would be very much interested. Because that is completely contradictory to one of the complaints that I always get from veterans that try to use that 800 number.

Mr. VIOLANTE. That is why we were—I was personally kind of surprised by the results. Because I expected the same thing, that we would get busy signals, we would be put on hold for long periods of times; and the survey just didn't show that.

(The information follows:)

July 25, 2001

Honorable Silvestre Reyes, Ranking Member
Subcommittee on Benefits
House Veterans' Affairs Committee
337 Cannon House Office Building
Washington, DC 20515-6338

Dear Representative Reyes:

Pursuant to your request at the Subcommittee hearing on July 10, 2001, I am enclosing a copy of the DAV survey of VA's toll-free phone number. I hope you find this information helpful.

I believe that the Subcommittee's decision to establish a pilot program for VA to expand its toll-free phone line was a prudent alternative.

If you need any further assistance or information, please do not hesitate to contact me.

Sincerely,

JOSEPH A. VIOLANTE
National Legislative Director

JAV:lmb
Enclosure
c: Chairman Simpson

NATIONAL SERVICE AND LEGISLATIVE HEADQUARTERS * 807 MAINE AVENUE, S.W. * WASHINGTON, D.C. 20024-2410 * PHONE (202) 554-3501 * FAX (202) 554-3581

SURVEY CONDUCTED MARCH 15 & 16, 2001

DAV Office	Blocked Calls (Busy Signals)	Call Time	Correct Answer? (yes/no)	Comments
Albuquerque, NM	0	8 minutes	No	Female employee was courteous and concerned about not having the phone number
Anchorage, AK	DNP	DNP	DNP	DNP
Atlanta, GA	0	9 minutes	No	Low voice started call on problem note, and the information provided was totally incorrect, although she did have a sound of confidence in her answer, if you could hear it
Baltimore, MD	DNP	DNP	DNP	DNP
Bay Pines, FL	0	3 minutes	Yes	
Boise, ID	0	2 minutes	Yes	The 800-number for VA assistance is transferred every Tuesday and Thursday from the Boise VARO to another station to do training. Veterans have called and complained about being transferred when requesting status of their claim
Boston, MA*	0	A. 5 minutes B. 3 minutes	A. No B. Yes	A. Disconnected after 5-minute wait on first call.
Buffalo, NY	0	9 minutes	No	Operator knew it was a wrong number she was giving; however she thought the right number would be available by calling this number. Unfortunately, the number given was a non-working number
Cheyenne, WY	DNP	DNP	DNP	DNP
Chicago, IL	DNP	DNP	DNP	DNP
Cleveland, OH	0	1 minute	Yes	
Columbia, SC	0	15-20 seconds	Yes	The only negative issue is that the initial automated information system may be difficult for some older and more rural veterans
Denver, CO	0	4 minutes	Yes	
Des Moines, IA	0	4 minutes	No	

Detroit, MI	0	9 minutes	No	Could not find new number for Agent Orange
Fargo, ND	0	8 minutes	No	Returned with Spina Bifida number but could not find new Agent Orange number
Fort Harrison, MT	DNP	DNP	DNP	DNP
Hartford, CT	14	7 minutes	Yes	
Honolulu, HI	0	5 minutes	No	
Houston, TX*	0	A. 2 minutes B. 5 minutes C. 5 minutes	No No No	Referred to the Houston VAMC Referred to the Houston VAMC Counselor took phone number, and said she would call back. Also said social worker would call back. All counselors were nice and polite, but did not have the number
Huntington, WV	DNP	DNP	DNP	DNP
Indianapolis, IN	0	7 minutes	Yes	Prompt and courteous
Jackson, MS	3	2 minutes	Yes	Prompt and courteous
Lincoln, NE	DNP	DNP	DNP	DNP
Little Rock, AR	0	9 minutes	Yes	Also gave the web address
Los Angeles, CA*	0	A. 3 minutes B. 3 minutes	No No	Referred to local VA hospital Referred to local VA hospital
Louisville, KY*	0	A. 3 minutes	Yes	
		B. 3 minutes	Yes	
		C. 3 minutes	Yes	Each call was very successful with a minimal waiting time. The counselors were pleasant. The choices through automation are somewhat helpful, but many choices could easily confuse a claimant as to what to push, which may lead to delays
Manchester, NH	0	1 minute	No	Counselor very polite and helpful. Did provide the direct URL to the Agent Orange web site, and offered to log on for him in the hopes of finding it during the conversation.
Manila, Philippines	DNP	DNP	DNP	DNP
Milwaukee, WI	0	5 minutes	Yes	
Montgomery, AL	0	3 minutes	No	Offered Medical Center number

Muskogee, OK	0	4 minutes	Yes	Quality and accuracy exceptional. Service Center Manager sent an e-mail to the phone bank crew with the correct information concerning the AO help line and information to be released
Nashville, TN*	0	A. 3 minutes	No	No one available at that time to take call
		B. 3 minutes	Yes	Quality of service excellent, courteous manner displayed by individual giving out information
New Orleans, LA	DNP	DNP	DNP	DNP
Newark, NJ	0	3 minutes	No	
New York, NY*	0	A. 8 minutes	No	
		B. 6 minutes	Yes	
Oakland, CA	0	1 minute	Yes	Quality was high and service was high—even asked questions of a counselor and was treated well
Philadelphia, PA	DNP	DNP	DNP	DNP
Phoenix, AZ	0	6 minutes	No	Person very helpful and courteous, but did not know the new Agent Orange number. Provided with three numbers, only one toll-free, and that one not the correct number
Pittsburgh, PA*	0	1 minute	Yes	All 8 calls were answered promptly and courteously. Always got correct information.
Portland, OR	0	13 minutes	Yes	Polite and courteous
Providence, RI	DNP	DNP	DNP	DNP
Reno, NV	DNP	DNP	DNP	DNP
Roanoke, VA	0	3 minutes	No	Never got though to a counselor---was not able to ask a counselor
Salt Lake City, UT	0	3 minutes	No	Given the number for the local VA hospital
San Diego, CA	0	9 minutes	Yes	Given the wrong info at first, then, after further inquiry, given the right toll-free number
San Juan, PR	DNP	DNP	DNP	DNP
Seattle, WA	0	4 minutes	Yes	
Sioux Falls, SD	DNP	DNP	DNP	DNP
St. Louis, MO	0	37 seconds	Yes	Friendly, courteous, and prompt
St. Paul, MN	0	5 minutes	No	

Togus, ME	0	2 minutes	Yes	Marginally polite and courteous
Waco, TX	0	3 minutes	Yes	
Washington, DC	unknown	unknown	No	VSRs not properly informed of the AO number, and only one in sample was able to track it down. Other VSRs
White River Junction, VT	0	7 minutes	Yes	
Wichita, KS*	0	A. 20 minutes	No	Recording ended call with information that the office was closed
		B. 21 minutes	Yes	
Wilmington, DE	DNP	DNP	DNP	DNP
Winston-Salem, NC*	0	A. unknown	No	Number could not be found
		B. unknown	No	Number could not be found
		C. unknown	No	Given wrong number
		D. unknown	No	Given wrong number
		E. unknown	No	Asked to call back later

DNP=Did Not Participate
*=More than one call made by office

Mr. REYES. Very good.

Let me ask you as panelists a question, again, in regards to the proposal not in the context of privatization but in the context of service to veterans that are out there and the needs that they have. When I looked at that legislation, I thought that it was a perfect opportunity for veterans to participate in the program, such as disabled veterans that would actually—in other words, my vision for that was a veteran talking to a veteran about an affliction, an ailment, a concern. Again, a veteran that had been trained in that.

Do you have any opinion on that in terms of—I know all of you are united against this proposal. But have you considered the fact that it could provide an opportunity for veterans to be talking to veterans about whatever issue is on their mind?

Mr. VIOLANTE. I don't know that the people working for VA that are answering the phones are not veterans. I know there is a large percentage within the Department that are veterans. I just—I have a difficult time in trying to figure out where all these new people are going to come from to provide this service. We have some serious concerns about that.

Mr. FISCHL. Also, I would be concerned that a little knowledge can be a dangerous thing. You know, you really don't want to give them bad advice. And we have all had that, where veterans told other veterans some things that weren't quite true that they sincerely believed in their heart were. You can do more harm than good, and we wouldn't want that to happen.

Mr. DANIELS. Mr. Chairman, I disagree. Let's make it interesting. I refuse to believe that the VA has a premium on good services. Outside organizations can be properly trained to dispense the information. And it is not like they are going to be doctors anyway, but they can be trained just as well as the people on the inside, veteran benefits counselors, to dispense the same information and perhaps alleviate these people to do other things.

Besides, contracting out is not like it is unheard of in the government. You go to Fannie Mae, Ginnie Mae. They all have outside sources that they contract with. I think they do a relatively good job as far as I am concerned.

Mr. REYES. That is actually what I envisioned was an opportunity for—listen, it comes down to this: 8 to 5, 5 days a week, or trying on a trial basis a program that gives 24-hour-a-day assistance to veterans.

You know, when you talk about—and you mentioned in your testimony that veterans have access to the Internet and all of these other things. I think you guys are forgetting the homeless vets. You are forgetting those that are traumatized by their experience in the military. You are forgetting those that have been frustrated because they have gone to the VA van, had to wait in some cases repeatedly day after day, 10, 8, 10 hours. I mean, there are a lot of—we must be talking to different veterans. I just don't understand why we wouldn't want to facilitate more access to information, the opportunity to train.

My first reaction to that legislative proposal was that this was a venue where a veteran could be trained—hired and trained to provide a service to a hotline that a veteran would be using, perhaps even veterans that have gone through recovering alcohol or

drug abuse. I mean, those hours are the ones where veterans most vulnerable to homelessness, depression, despair, all kinds of things. I just—like I say, I am very surprised that you would take that position, but——

Mr. VIOLANTE. Mr. Reyes, we are certainly not opposed to expanding those services, making them 24 hours a day, adding crisis intervention. Our concern is moving it over into the private sector.

Mr. REYES. Well, you realize that if it stays with the VA—and, you know, I have concerns about contracting out as well. But in the context of the requirements put upon by employees of the Veterans Administration, that—this may be an opportunity to hire additional veterans with expertise and background that would help those very veterans that are today disenfranchised, the ones that are on alcohol, drugs, depressed, deprived and all of those kinds of issues. But just one man's opinion.

Thank you, Mr. Chairman.

Mr. SIMPSON. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Is it Mr. Fischl? Is that how you say it?

Mr. FISCHL. Fischl.

Mr. SNYDER. Fischl.

I think I will direct this question to you, if I might, since you talked about this in more detail. But if I can just play devil's advocate about this diabetes issue, and I understand the perspective that putting in a statute is not going to change anything at this point but would send a message that we don't want to change. But my guess is that at some point—I don't know if it would be in our lifetime or not—at some point, we may well want that changed. Let me just give you an example.

Let's suppose that 10 years from now we don't have a Type 1, Type 2, but we have a Type 1, Type 2, Type 3, Type 4, Type 5, Type 6; and we figured out that Types 4, 5 and 6 are strikingly related to some chemical exposure from a previous combat situation. It seems like the more that we put in the statute, these kinds of essentially regulatory things, that it does make it more difficult to change as medical knowledge changes.

I just—I don't think I expect to you comment on that, but I—you know, sometimes it may make sense just to declare victory and go home and recognize that we all decide that we want to have this changed at some point down the line before we all pass away, the Vietnam veterans among us; and that that would make it harder to get it changed by having it in statute. But I just throw that out.

I want to ask you, the 75 percent denial rate has been cited by you and by Congressman Manzullo. A couple of questions. How do you respond to what Mr. Thompson said about the 75 percent, they do get some kind of other benefit? And what do you consider to be an acceptable denial rate?

Mr. FISCHL. An acceptable denial rate, that would be difficult. Obviously, we would favor a lower denial rate.

But I would say that what Mr. Thompson was referring to would be perhaps receiving compensation for, you know, a bad knee or something that is not at all related to Persian Gulf service. I don't have access to those statistics. I would like to see them.

But we are trying to talk specifically about Persian Gulf illness, and we feel that because of the problems with—you know, physicians tend to want to diagnose, and they will come up with a diagnosis. If they do that, they kill the whole idea of undiagnosed illness. And——

Mr. SNYDER. Is part of the problem here—I guess it is to all three of you. Is part of the problem that we are having in these—because these are difficult cases, are they not, where you have got one physician who says, well, that is osteoarthritis in those joints; and someone else says, wait a minute, I am starting to see a constellation of symptoms that may be related to something else; and you go back to the chart.

I mean, I am a physician; and we have all changed our diagnosis, you know, on somebody who comes in and we think they have got something simple and then a year from then we figure out that it is really something complex. So the cases are complicated. The medical records are complicated. There may be multiple medical records because people doctor shop because they get frustrated.

Is part of the problem, this backup that we are having now in the benefit section where we have just got a lot of frustrated—I visited with Secretary Principi in Little Rock a couple of months ago, with her and compensation benefits people. A very frustrated group of people, good dedicated employees. Some of them have been there 15, 20 years, never had such high frustration. Do you think that is part of the problem in sorting through these cases, that these are the difficult cases and people don't really have time or choose to put their time in other, more simple cases or what are your thoughts on that?

Mr. FISCHL. I wouldn't disagree with that. I think they do get frustrated. They are difficult. You know you have to make a decision. We boil a complex issue down to—and a very vague issue down to an either yes or no.

Because service connection either is or it isn't, and you have symptoms that are all over the map, and maybe it could or maybe it couldn't be, and you are approaching that line, you know, where you are right in the middle. Is it yes or is it no? I think that is part of the frustration and the problem.

Mr. VIOLANTE. Clearly, I have to agree with that. You know, the backlogs are a part of the problem, but this whole Gulf War situation is further complicated by the fact that we don't know what is causing these disabilities. We don't exactly know what these disabilities are, what they are limited to or how extensive they are; and it becomes very difficult. And particularly under the current law, an undiagnosed illness, if you, you know, the veteran gets a diagnosis, then he is no longer entitled to compensation.

So there are just a lot of factors that come into play that make this situation a little more complicated than it is for others.

Mr. DANIELS. And I concur, sir.

Mr. SNYDER. The last—and I think this is more in the way of comment also. You know, the concerns about the telephone service—and I appreciate your comments about that, about wanting to go to 24 hours and wanting to have more information, more accurate information, all those kind of things that we all want and then the terrible problem we have in the backup in compensation.

I tell you what. I was disappointed in, I guess, the performance of all of us when this budget cycle, you know, to have the House number come out at one level, to have the Senate number come out at one level, and when it comes out from Congress to have the numbers for veterans be lower than both, I think we all failed veterans. So now we are talking about, well, let's come up with some more money. We need to expand services. You know, we should have had this conversation 3 or 4 months ago, I think. Thank you.

Mr. SIMPSON. Thank you. And I thank the panel for their testimony and look forward to working with you to address these issues. Thank you all very much.

We have the pleasure of having Mr. Baker with us to present testimony on his bill, something we weren't anticipating. So it is a special pleasure to have you here today. Before we call the fourth panel I am going to allow Mr. Baker to testify on his legislation, H.R. 1746. Mr. Baker.

STATEMENT OF HON. RICHARD H. BAKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. BAKER. Thank you, Mr. Chairman. If appropriate, I guess from here is fine?

Thank you, sir. I do appreciate your courtesy in conducting this hearing. I was not sure my travel plans would permit me to arrive in time for the hearing today.

I also, Mr. Chairman, took the effort to make one last phone call from my office before I came here this morning to 1–800 827–1000, just to make sure I wasn't missing anything. And I would just say to all the members of the committee, before you make final judgment on the disposition of this legislation, dial the number. Pick an area where you have an interest. I did it one more time for a disability claim, not military related.

Imagine yourself a World War II veteran who is now 78 years of age, going through the screens and being referred from one section to another and then being told at the end of the conversation, please request form 21526/B, and it goes on. You have individuals who all too often are already frustrated by the years of what they often feel is an inappropriate level of sensitivity to their difficulties.

All that I am asking—and I think many members of the committee feel similarly inclined but have problems with the budget implications—is for a human being to speak to the veterans and direct them to the appropriate local service organization for dispensation of their claim.

It appears to me that there is some division among the veterans' groups as to the advisability of the proposal. But in speaking with them in my office, it was apparent their concerns don't go to whether we should provide this quality of services but whether in an attempt to provide the service it will result in a reduction of services elsewhere within the agency, on the belief that we would rather have poor phone service and ultimately find a caseworker who will deal with my case, as opposed to being directed quickly at the beginning to a caseworker who may have more workload. I think that is the policy decision with which the committee is confronted.

I certainly would join in the comments of the gentleman who just finished with regard to the treatment of the veterans' budget, and I certainly would like to have seen enhanced resources made available. But I did broach this topic with the—in a committee hearing much earlier in the year and appreciate the chairman's willingness to have the hearing on it today, but it has been merely a matter of timing in bringing the subject before the committee and having the opportunity to speak to the justification for it.

I also looked at the survey numbers as generated by the agency's own study and looking at the number of veterans who feel they have adequate knowledge of veterans services, and the survey says 56 percent, 17.8 percent of veterans believe the VA keeps them apprised of the full range of benefits that are available, and 26 percent feel that the VA told them about their benefits for which they might be eligible. So you have really a very low level of customer satisfaction.

I would suggest that if we were operating on constituent service response within our respective districts and only had 55 percent of the people feel like we were telling them what they need to know we would be wanting to change our method of operation.

My request is just based on personal experience. I have made the phone call many times now since I first brought it up in committee because I didn't realize it would get the interest it did receive. And with all respect to those who are doing a very difficult job with limited budgets the method of response today is, in my view, not satisfactory. Whatever it takes, I will assist the Chair and the members of the committee in supporting whatever measures may be necessary. And if it—and I hate to say the words, knowing what Washington study means, but if further study is required, I certainly would be willing to understand that.

But from a casual observation, the process—having visited with representatives of the agency, representatives of veterans' organizations and having called about 20 minutes ago, my opinions have not changed over the course of the last few months.

I do appreciate your courtesy, Mr. Chairman, and look forward to working with you in any manner possible.

Mr. SIMPSON. I thank you for your testimony, and I look forward to working with you to address this.

Do any members of the committee have any questions?

Appreciate it. Thank you for getting here today and testifying. Thank you.

[The prepared statement of Congressman Baker, with attachment, appears on p. 136.]

Mr. SIMPSON. Our fourth panel today are also representatives of the veterans' community: Mr. David Tucker of the Paralyzed Veterans of America; Mr. Richard Jones of AMVETS; and Mr. Selfon, Vietnam Veterans of America.

I welcome you all to the committee. Thank you for being here today.

STATEMENTS OF DAVID M. TUCKER, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND LEONARD J. SELFON, ESQ., DIRECTOR OF VETERANS' BENEFITS PROGRAMS, VIETNAM VETERANS OF AMERICA

Mr. SIMPSON. Mr. Tucker, you may begin.

STATEMENT OF DAVID M. TUCKER

Mr. TUCKER. Thank you, Chairman Simpson, Ranking Member Reyes, Congressman Snyder, Congressman Baker. On behalf of the Paralyzed Veterans of America I am pleased to present our views of pending benefits related to legislation before the subcommittee.

I would also like to offer our congratulations to you on becoming chairman. We look forward to working closely with you and Mr. Reyes to do a lot of good for veterans all across this country.

Veterans' benefits are a means for a nation to recognize and reward service as well as to encourage future generations to serve with the promise that these benefits will be there for them. The benefits measures we will address today send a message, a message meant to assure the men and women who serve in our Armed Forces that we will not forget their sacrifices or their service.

For veterans to receive benefits earned by their service and their sacrifices, they must first be made aware of them. Two measures, H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001, and H.R. 1746, a bill that would require the Department of Veterans Affairs to establish a single toll-free telephone number offered by Congressman Baker, are attempts to accomplish this important goal.

Although we fully support the intentions underlying these bills, at this time we are unable to support either of these two measures. We note that the VA already has a toll-free telephone number to respond to informational requests; and even though it is from many, many people's experience inadequate, I think we should look forward to working with the VA as veterans' groups and as Members of Congress to improve this service.

We also believe that this should be kept within the VA. If there are to be additional informational resources, the VA has the expertise and has the people in place. So let's just move forward together to try to get this situation solved and improved.

As mandated by the VA effective yesterday, Type 2 diabetes will be added to the growing list of diseases that are presumed to be service connected as a result of exposure to herbicides. Recognizing the need of those affected by Type 2 diabetes is paramount to successfully improving their quality of life, we do not oppose H.R. 862, but we feel it is unnecessary, given the actions undertaken already by the VA that are currently authorized and mandated by title 38.

If the subcommittee wishes to move forward to codify, we suggest that the subcommittee also add the two diseases listed in regulation now that are not currently found in title 38.

We do not oppose H.R. 1406, the Gulf War Undiagnosed Illness Act of 2001.

We have stated in testimony before the Senate that we do not oppose S. 409, the Senate bill and the House bill, the accompanying

bill introduced by Congressman Manzullo. We believe that a more inclusive definition of an undiagnosed illness is necessary, and we note that section 2 of H.R. 1406 is a meaningful step forward in accomplishing this goal.

We also believe that action must be taken to extend the presumptive period currently slated to end this December. We are aware that the VA has undertaken a review to determine if the presumptive period should be extended. If the VA decides this period should not be extended, then we believe that prompt legislative action will be necessary.

We support H.R. 1929, the Native American Veterans Home Loan Act of 2001. We believe, as we have testified before the Senate, that this is a successful pilot program and should be made permanent. We believe that section 3 of this measure, authorizing the use of other Federal memoranda of understanding, is an innovative idea that could mean many more Native Americans taking advantage of this program. We also believe that the reporting requirements contained in title 38 should also be extended through 2005 or, if this program is made permanent as we recommend, extended indefinitely. These reporting requirements are slated to expire in 2002.

We have concerns regarding section 1 of H.R. 2359 regarding the insurance provisions. Many designated beneficiaries may not even be aware that they are beneficiaries and hence would not be able to make a claim within the 2-year time period established by this legislation. In addition, the section grants too much discretion to the Secretary to determine who may be, "equitably entitled to the proceeds of the policy." PVA believes that the wishes of policyholders should be followed as far as is practicable. Perhaps the VA should be more aggressive in locating and notifying beneficiaries.

Of course, we would also like to see what the VA is doing right now along these lines. We are not completely opposed to looking at something down the road but at the present we don't see the real need of these provisions.

Finally, we do not oppose section 3 of H.R. 2359. That section would eliminate the requirement for providing a copy of a Notice of Appeal filed with the Court of Appeals for Veterans Claims with the Secretary.

We support H.R. 2361, the Veterans' Compensation Cost-of-Living Adjustment Act of 2001. But we do oppose again this year, as we have in the past, the provision rounding down to the nearest whole dollar compensation increases. This was a means for deficit reduction, and veterans have paid their fair share for reducing our deficit, and since we supposedly no longer have a deficit, I think we need to do away with this provision.

The way we treat veterans today will either encourage or discourage the men and woman currently contemplating service. That is why it is so important that benefits promised be delivered and that these benefits maintain their original goals and their original intentions. The availability as well as the scope of benefits sends a clear message concerning the importance of military service to this Nation and to those who are veterans and to those who will be veterans in the future.

This concludes PVA's testimony concerning benefits- related legislation for the subcommittee, and I will be happy to answer any questions that you all may have.

Thank you.

[The prepared statement of Mr. Tucker appears on p. 143.]

Mr. SIMPSON. Thank you, Mr. Tucker. Mr. SIMPSON. Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Chairman Simpson, members of this distinguished subcommittee, AMVETS is pleased to present testimony on proposed veterans' benefits legislation. We deeply appreciate the commitment of this subcommittee and its members to address the concerns of veterans.

AMVETS supports the legislative measures before this committee. We believe that approval of these bills would enhance and improve service-connected benefits and related services for American veterans and their families.

H.R. 862, to add Type 2 diabetes. AMVETS support the legislation. Last November, the Academy of Sciences' Institute of Medicine reported a "limited" evidence between Type 2 diabetes and Agent Orange defoliant used in Vietnam. The Department of Veterans Affairs followed the IOM report announcing that it would accept benefit claims if a veteran served in the Republic of Vietnam during the war period, making the disease presumptively service connected. H.R. 862 would list the disease as being associated with Agent Orange. We believe this is appropriate. It also would include U.S. personnel deployed to Korea when Agent Orange was sprayed in 1968 and 1969. AMVETS supports this as well.

H.R. 1406, the Gulf War Undiagnosed Illness Act. AMVETS recognizes that, 10 years after driving Iraq from Kuwait, many Desert Storm veterans continue to suffer from debilitating ailments that medical science cannot accurately diagnose. Nearly one of every seven military personnel who served in the Gulf have sought Federal help for illnesses they think stem from exposure to prescribed drugs or chemical warfare agents used in the region. Despite enactment of legislation in 1994 to compensate veterans for unexplained multiple symptom illnesses, there exists today a 75 percent denial rate for Gulf War veterans seeking help. AMVETS supports America's veterans. We ask only that those men and women be provided appropriate medical and psychological services. They were healthy and strong when they protected our overseas interests. Now they face serious and unexplainable illnesses.

Mr. JONES. H.R. 1406 would clarify the definition of "undiagnosed" and help provide appropriate care and compensation for these veterans.

H.R. 1435, to award grants to provide for a national toll-free hotline: AMVETS supports the establishment of a national toll-free telephone service to VA for veterans and dependents. The establishment of a national information and assistance hotline could serve to further strengthen VA's integrity for veterans' services. While we do not understand why the operation of a hotline should be conducted by a private, nonprofit entity, we feel such a service would complement a series of 800 services already available to veterans and dependents, including one for VA Benefits, for Life In-

surance, for Debt Management Center, for CHAMPVA, for Headstones and Markers, and the Persian Gulf Hotline, among others. VA does a good job, but these things could be strengthened.

H.R. 1924, the Native American Veterans Home Loan Act: AMVETS supports the extension of the Native American Veterans Housing Loan Program. It would extend the pilot program for veterans living on trust lands that began in 1993 to December 31, 2005. The program was a good idea when it was begun, and it continues to serve an important segment of the veterans community.

AMVETS supports passage of H.R. 2359, to authorize payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, and also it would improve and extend the Native American Veterans Housing Loan Pilot Program in some capacity and would also eliminate the requirement to provide the Secretary of Veterans' Affairs a copy of a notice of appeal.

Regarding section 1, AMVETS would inquire of the subcommittee as to whether VA provides notice to the first beneficiary on entitlement to payment of the insurance proceeds following the death of the insured. Regarding section 2, AMVETS agrees that it is entirely appropriate that the VA or its authorized agent approve assumption of the original loan. Such agreement is critical to this program's integrity. AMVETS has no position on Section 3, eliminating notice of appeal to the Secretary.

AMVETS supports H.R. 2361, the Veterans' Compensation Cost of Living Adjustment Act. This legislation would increase the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for certain disabled veterans. While we strongly believe that the rate adjustment should be established yearly at a more generous margin than the percentage rate increase established annually under Title II of the Social Security Act, we support the legislation. Clearly, Congress must adjust these rates to avoid eroding their value.

Again, AMVETS sincerely appreciates the opportunity to submit our viewpoint on these issues, and we again thank the subcommittee for its vigilance in improving benefits and services to veterans and their families. Thank you.

[The prepared statement of Mr. Jones appears on p. 150.]

Mr. SIMPSON. Thank you, Mr. Jones. Mr. Selfon.

STATEMENT OF LEONARD J. SELFON

Mr. SELFON. Good afternoon. Mr. Chairman, other distinguished members of the committee, on behalf of the Vietnam Veterans of America, I am pleased to have this opportunity to present our views with respect to several important pieces of veterans benefits and services-related legislation.

First up is H.R. 862, Presumptive Service Connection for Diabetes Mellitus, Type II. Almost a decade ago, we would note that Congress passed the Agent Orange Act of 1991, which provided the Secretary of the VA with the authority to establish presumptive service connection for those diseases that have been scientifically demonstrated to be associated with exposure to chemical defoliants, such as Agent Orange and other herbicidal agents during the Vietnam War.

Until recently, nine diseases were presumptively considered to be the result of exposure to Agent Orange that was used during the Vietnam War. Nevertheless, that list of presumptive diseases did not include Type II diabetes. In April and October 2000, VVA petitioned the Secretary to promulgate regulations to provide presumptive service connection for Type II diabetes as a result of such exposure. Veterans have been severely affected by this disease for years without any well-deserved compensatory relief or desperately needed health care, which is often the result of being service connected.

In view of the Institute of Medicine's October 2000 announced determination that there is limited or suggestive evidence of a relationship between diabetes and Agent Orange, it became clear that the time had come for the VA to establish presumptive service connection for diabetes, Type II.

On May 8, 2000, the VA published a final rule in the Federal Register that added Type II diabetes to the list of presumptive diseases, effective as of July 9, 2001. And at first glance, H.R. 862, which would also add Type II diabetes to that list, would appear to be somewhat moot in light of the VA's final regulation. But nevertheless, VVA urges the swift passage of this legislation to preclude the VA from removing or curtailing this new disability benefit in the future, but we would encourage Congress to go further.

In its May 2000, Federal Register notice, the VA addressed two aspects concerning subsequent awards of presumptive service connection for diabetes, Type II, with which VVA takes exception. First is the issue of extending this presumption to those service personnel who were exposed to Agent Orange during their military service but not actually within the geographical boundaries of Vietnam. Specifically we are referring to exposure in the territorial waters off Vietnam and in other locations where there was documented use of Agent Orange, such as Panama and Korea and even Fort Drum, New York.

Pursuant to section 1116, there is a presumption of exposure to Agent Orange and other herbicides for service personnel that served within the geographic boundaries of Vietnam, and 1116 requires that a veteran have served within Vietnam to be eligible for the presumption of exposure. But the VA regulations and a VA General Counsel precedent opinion provide that service in a deep water vessel off the coast of Vietnam is not sufficient to constitute service within Vietnam, and essentially the veteran, to be entitled to the presumption of exposure, the ship would have to dock and the veteran would have to disembark and actually touch ground in Vietnam to be afforded the presumption of exposure. And similarly, there is no legal authority for the VA right now to afford presumptive service connection for those exposed to herbicidal agents in other venues, such as Panama, Korea and, again, Fort Drum.

Therefore, VVA encourages Congress to amend 1116 to apply the presumption of exposure not only to service in Vietnam, but also to service in the waters offshore, as well as for anyone serving in any other location where there has been generally documented use of Agent Orange or other herbicides.

The second issue of concern that we have involves the retroactivity of awards of presumptive service connection for Agent Orange-related Type II diabetes. Veterans have been filing claims for

this disorder for years and they have been consistently denied. The problem is that 1116 also provides that VA regulations promulgated as the result of the Secretary's conclusion that there is an association between the disease and exposure shall be effective on the date that the regulation was issued, in this case, for diabetes, July 9, 2001.

We maintain that in order to ameliorate the inequity of delayed recognition of the impact of service-connected diabetes on the lives of veterans and their families, that Congress include in 862 a provision establishing an effective date for presumptive service connection retroactive to the date of filing of an original claim for that disorder. We believe that that directive would be consistent with the *Nehmer* case in the Northern District of California, which has held that awards of compensation made under regulations on the basis of 1116 be made retroactive for the dates of an earlier claim or an original claim before the issuance of such regulations.

Generally, most medical professionals would agree that we have kind of scratched the surface with respect to understanding the long-term effects of toxic exposures and many of the current studies relied on by the IOM and the VA, including the Air Force's Ranch Hand study, are woefully inadequate to present a true picture of the devastating effects of exposure to herbicides. Findings are gender biased, because most of the study population consisted only of men. Other studies extrapolate conclusions merely from the examination of dirt and fish. We request that Congress consider more funding and research that is required to even approach the level of understanding necessary to compensate our suffering veterans.

We would also call on Congress to make available significant funding for dioxin and in-country effects studies into the possible adverse health effects of exposure to herbicides during the Vietnam era.

H.R. 1406, the Gulf War Undiagnosed Illness Act of 2001: The purpose of this bill is to improve presumptive disability compensation benefits for veterans who suffer from poorly defined illnesses as a result of their Gulf War service, and the existing statute would be included an expanded definition or description of the undiagnosed illnesses. We support that very strongly, because evidence has demonstrated that the VA has interpreted existing statutory language as narrowly as possible, as evidenced by their 75 percent denial rate.

We also support the provision of the bill that would preclude making available information from participation in VA studies, and we would ask that Congress also make sure that the Secretary takes affirmative efforts to keep that information out of the hands of the adjudicators so that they will not be adversely influenced in their decisions.

As far as the telephone bills are concerned, we support both. We are aware of the current problems with the toll-free number. It is basically an inefficient, uninformative and often very frustrating process for the veterans, and we feel that a national single nationwide toll-free number, with knowledgeable operators and counselors, would go a long way to rectify those problems. If certainly not a replacement, at least an augmentation of that program.

We also support the Native American Home Loan Act of 2001. We request that this pilot program be made permanent in nature and the program indefinitely extended.

We are also supportive of the NSLI/USGLI beneficiary provisions, but we would also request that the definition of a timely claim be extended as well.

As far as H.R. 2359, Section 3, with regard to the notice of appeal, under the Court's current rules of procedure, nothing really happens until the Court issues a notice of docketing, which happens after the Court receives the notice of appeal. Since the VA does not begin to construct the designation of the record until after the notice of docketing has been issued by the Court clerk, there would be no practical effect to the rescission of that requirement. So we support that as well.

And finally, we support the cost of living provisions. Disabled veterans and their families fall victim to rising costs of living no less than anyone else, and these measures are necessary to prevent them from falling through inflationary cracks.

And if I could just finish up here, I would like to say that I would be remiss if I did not note VVA's disappointment that there were no hepatitis C health care or presumptive service-connection measures on today's agenda, but we hope that legislation in that regard will certainly become a reality.

Mr. Chairman, and members of the subcommittee, I would like to thank you again on behalf of VVA for the opportunity to comment on these bills today.

[The prepared statement of Mr. Selfon appears on p. 155.]

Mr. SIMPSON. Thank you for your testimony today. Mr. Reyes?

Mr. REYES. Thank you, Mr. Chairman. Just to put the issue in context, are any of you gentlemen aware of any veterans who have recently developed symptoms of undiagnosed illnesses? The reason I ask that is there are two schools of thought, one for the extension in the event that we are dealing with an issue that we obviously don't know everything about already. The other one is that if it was going to come up, it should have come up by now, which in addition to that or an addendum to that would be perhaps we ought to consider legislation that would give veterans a 10-year reckoning period, post leaving the Gulf War region.

Do any—well, let me have an opinion from each one of you.

Mr. TUCKER. We are certainly not experts in Persian Gulf Syndrome at PVA, but I think our view is that we definitely need this period extended. It expires at the end of this year, and we still don't know what is causing this or what really is happening, and so I think it would be remiss for us to let this opportunity pass. The VA does have the authority under Title 38 to extend this period on their own volition. So I think we should see what they are going to do, and if they fail to extend this period, I think we should move forward legislatively.

Mr. JONES. Mr. Reyes, I am unfamiliar with the reporting pace of incidences of Gulf War Syndrome. However, I would see no problem with extending the period. I am not sure there is an expense to it. There is a possibility that there could be individuals who experience delayed reaction. It is hard to define the elements that

cause this problem and to set a time line on it. I see no problem with extending it. The time line is short-sighted perhaps.

Mr. SELFON. VVA is extremely in favor of extending the time lines. We think we can take a good long lesson from the impacts of Agent Orange. I think it is very analogous. It is 25, 30 years after certain persons' exposures to herbicides and other toxic environments in Vietnam. The Gulf War veterans were faced with a different set of endemic diseases and toxins, but the principles still remain the same. It is 25, 30 years later and the IOM is still finding relationships between not only diseases in veterans but in their children, spina bifida being one example, and then most recently the IOM found a relationship between acute myelogenous leukemia in children and the VA has announced that they are going to go ahead and try to promulgate some kind of compensation or health care for those children as well.

So because of the medical and scientific uncertainties that we face with regard to Gulf War illness, as we have with Agent Orange-related disorders, that is justification, in our minds, alone for the extension.

We would also note that we do have some Gulf War clients that have been service-connected for more traditional type of injuries, you know, combat wounds, bad backs, hearing loss and things like that, but at the same time, they have also been developing these nebulous constellations of symptoms that have not been diagnosed. The VA has typically been denying the claims for Gulf War illness, because there are some diagnoses. And we have been somewhat successful going back to the VA and getting medical opinions saying that, okay, let us separate the diagnosed illnesses, but you still have a couple of symptoms out there that are unexplained, and have the VA consider Gulf War illness on the basis of those symptoms alone based on medical evidence. So, again, because of the uncertainties involved, we strongly believe that the presumptive period should be extended.

Mr. REYES. And the only other issue is the one about the 800 number and the availability, and I know you gentlemen heard my comments earlier about being there for the veterans when they need the service versus when it is convenient. Can you speak to that issue as well?

Mr. TUCKER. Sure. I think we agree with you. The VA should be providing this service 24 hours a day, 7 days a week. I think the problem that we have with both of these pieces of legislation is that on one hand we are asking the VA to provide an 800 number that is its sole 800 number. The VA provides an 800 number now that people are not happy with, so how is this new 800 number going to be any more successful? We really do need to get the VA to improve the system. I think our problems with turning the program over to a private, nonprofit contractor is that this is a core duty of the VA to provide this information, and we find it difficult to believe that you are going to be able to provide the resources for all the veterans who are going to be calling in. If they have alcohol problems, if they are having problems getting a home loan, if they are having problems with their compensation claims, how is a private entity going to provide the myriad of services even more efficiently than the VA is doing it right now? They may need to talk

to a psychiatrist. They may need to talk to a lawyer. They may need to talk to a counselor.

We just have some real grave concerns with this, and we really think that we can work together to improve what the VA is doing right now, and if down the road we find that they can't, then we can look at other alternatives.

Mr. REYES. Well, and this is an alternative, and how do we know—again, not to beat a dead horse, but I just—somebody representing the Paralyzed Veterans of America ought to be saying this is a perfect venue for my constituency to be able to participate in a program that traditionally is thinking outside the box. One of the biggest problems with this program being done in the context of the VA is the ability to hire and pass all the requirements to be a Federal employee. A private entity would have the ability to hire, as I said, rehabilitated veterans, that possibly I think, from my own practical experience of dealing with some of the people that I know served in Vietnam, and not necessarily with me at the same time but we have that experience in common, about talking them through periods of depression and crises and all those kinds of things. I just think this is a good opportunity to do some of that. But go ahead.

Mr. TUCKER. If I can just add real quickly, I think we agree. We have veterans who call us as an organization asking for help. Many of them are not paralyzed. Many of them aren't our members or wouldn't even qualify as our members and we try to turn them over to our service officers that are located all across the country to provide assistance. I think we are just asking in H.R. 1435 for one group to be doing everything, and I don't know if that is possible, and I think we might have unrealistic expectations of what those services could provide, what those people could provide as services. The idea of having a hotline that is well publicized, that veterans all across the country would know the number to call if they had any questions and any problems is a fantastic idea, but I think if you look at the practical effects of it, I think we have really some grave concerns with it.

Mr. JONES. AMVETS does believe this to be a viable alternative and could very well be helpful, but we wonder, however, why it would be limited to only nonprofits. This great body ought to be able to include the very basis with—the strength of this country, the entrepreneurial spirit of veterans, as well as nonveterans. The economy is broad. We would hope that the grantees might be less limited, more expansive and we see this as a viable alternative.

Mr. SELFON. VVA believes that this is a good measure. We think that this can very broadly augment the existing toll-free number. There are admittedly problems with it, but bringing in the expertise of outside consultants could certainly assist the VA in developing their own infrastructure and improving the services on their hotline, as well as presenting them with the options of the—especially in terms of crisis counseling, being available after hours with trained professionals. Certainly private entities could supply that as well. So we believe that it is definitely a move in the right direction and may actually force VA to fix the bugs in their own system already.

Mr. SIMPSON. Thank you. Mr. Snyder.

Mr. SNYDER. I have no questions. Thank you, Mr. Chairman.

Mr. SIMPSON. Thank you. I would just like to point out, we do have difficulty in this whole area of diseases caused by service in the Gulf and also with the Agent Orange and other things, but you mentioned spina bifida, for dependents of those exposed to Agent Orange. And it is my understanding that was originally based on a study done by the Australians. Wait a minute, never mind, I am incorrect. It won't be the first time. Obviously we have some difficulty in trying to find what these are and if they are service-related and so forth. It is extremely difficult, it seems like to me, to determine if they are service-related and whether they ought to be included. And the length of time that it takes to determine, who knows when these things are going to—when the exposure is going to manifest itself, and that makes it extremely difficult also.

I want to say that our Secretary, Mr. Principi, saw the effects of the Agent Orange defoliant as a river boat pilot commander in the Mekong Delta. Indeed then-Deputy Principi and Secretary Derwinski, based on the Centers for Disease Control analysis, asked for and took steps to make non-Hodgkin's lymphoma and soft tissue sarcoma a presumption of service connection, and lastly, based on the National Academy of Sciences analysis, Derwinski and Principi requested in the early 1990s they can check service connection for long-term residuals of mustard gas exposure. So I think we do have a Secretary who has proven he is ready to do the right thing by the vets as he sees it, and we need to work with him and the scientific community to get the best possible analysis we can of these issues so that this committee and Congress does the right thing by the veterans also.

I thank you all for your testimony today and for being here today. I would let the committee know that we do have a statement here from the Desert Storm Battle Registry, and this statement will be included in the committee's official hearing file.

(The statement of Desert Storm Battle Registry is retained in committee files.)

Mr. SIMPSON. It has been an interesting hearing so far on this subject, my first hearing as chairman, and obviously there will be other times when I don't know what I am talking about either. But I am certain that there are many out there who will straighten me out, and I look forward to working with all the VSOs and the staff and getting to know them better and working hard with you to address these issues and make sure our veterans are taken care of, as we all anticipate they should be. Thank you all, and this committee hearing is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

APPENDIX

I

107TH CONGRESS
1ST SESSION

H. R. 862

To amend title 38, United States Code, to add Diabetes Mellitus (Type 2) to the list of diseases presumed to be service-connected for veterans exposed to certain herbicide agents.

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 2001

Mr. EVANS (for himself, Mr. FILNER, Mr. REYES, Ms. BROWN of Florida, Mr. RODRIGUEZ, Mr. SHOWS, Mr. BONIOR, Mr. CONDIT, Mr. CRAMER, Mr. EDWARDS, Mr. FRANK, Mr. FROST, Mr. KLECZKA, Ms. MCKINNEY, Mr. MASCARA, Mrs. MEEK of Florida, Mr. PASCRELL, Ms. SCHAKOWSKY, Ms. BALDWIN, and Mr. BRADY of Pennsylvania) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to add Diabetes Mellitus (Type 2) to the list of diseases presumed to be service-connected for veterans exposed to certain herbicide agents.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. PRESUMPTION THAT DIABETES MELLITUS**
2 **(TYPE 2) IS SERVICE-CONNECTED.**

3 Section 1116(a)(2) of title 38, United States Code,
4 is amended by adding at the end the following new sub-
5 paragraph:

6 "(H) Diabetes Mellitus (Type 2).".

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107TH CONGRESS
1ST SESSION

H. R. 1406

To amend title 38, United States Code, to improve presumptive compensation benefits for veterans with ill-defined illnesses resulting from the Persian Gulf War, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2001

Mr. EVANS (for himself, Mr. REYES, Mrs. CAPPS, and Mr. DOYLE) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve presumptive compensation benefits for veterans with ill-defined illnesses resulting from the Persian Gulf War, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Gulf War Undiagnosed
5 Illness Act of 2001".

1 **SEC. 2. INCLUSION OF ILL-DEFINED ILLNESSES IN PRE-**
2 **SUMPTION OF SERVICE CONNECTION.**

3 (a) IN GENERAL.—Subsection (a) of section 1117 of
4 title 38, United States Code, is amended by inserting "or
5 fibromyalgia, chronic fatigue syndrome, a chronic multi-
6 symptom illness, or any other ill-defined illness (or com-
7 bination of ill-defined illnesses)" after "illnesses)".

8 (b) CONFORMING AMENDMENT.—Subsection (c) of
9 such section is amended by inserting "or fibromyalgia,
10 chronic fatigue syndrome, a chronic multisymptom illness,
11 or any other ill-defined illness (or combination of ill-de-
12 fined illnesses)" after "illnesses)".

13 **SEC. 3. COMPENSATION FOR UNDIAGNOSED ILLNESSES TO**
14 **PROVIDE FOR PARTICIPATION IN RESEARCH**
15 **PROJECTS.**

16 (a) AUTHORITY FOR SECRETARY TO PROVIDE FOR
17 PARTICIPATION WITHOUT LOSS OF BENEFITS.—Section
18 1117 of title 38, United States Code, is amended by add-
19 ing at the end the following new subsection:

20 "(g)(1) If the Secretary determines with respect to
21 a medical research project sponsored by the Department
22 that it is necessary for the conduct of that project that
23 Persian Gulf veterans in receipt of compensation under
24 this section or section 1118 of this title participate in the
25 project without fear of loss of compensation benefits under
26 either section, the Secretary may provide that medical in-

1 formation derived directly or indirectly from the participa-
2 tion of a Persian Gulf veteran in that research project may
3 not be used in adjudicating that veteran's entitlement to
4 receipt of such compensation.

5 "(2) The Secretary shall publish in the Federal Reg-
6 ister a notice of each determination made by the Secretary
7 under paragraph (1) with respect to a medical research
8 project.".

9 (b) EFFECTIVE DATE.—The authority provided by
10 subsection (g) of section 1117 of title 38, United States
11 Code, as added by subsection (a), may be used by the Sec-
12 retary of Veterans Affairs with respect to any medical re-
13 search project of the Department of Veterans Affairs,
14 whether commenced before, on, or after the date of the
15 enactment of this Act.

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107TH CONGRESS
1ST SESSION

H. R. 1435

To authorize the Secretary of Veterans Affairs to award grants to provide for a national toll-free hotline to provide information and assistance to veterans.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2001

Mrs. CAPPS (for herself, Mr. EVANS, Mr. TOWNS, Ms. JACKSON-LEE of Texas, Mr. LUTHER, Ms. NORTON, Mr. MOORE, Mr. KILDEE, Mr. ROSS, Mr. OWENS, Ms. WOOLSEY, Mr. DOYLE, Mr. LANTOS, Mr. GONZALEZ, Ms. MCKINNEY, Mr. BLUMENAUER, Mr. SANDERS, Mr. HOLDEN, Ms. WATERS, Mr. HONDA, Mr. PASCRELL, Mrs. MALONEY of New York, Mrs. CHRISTENSEN, Mr. STRICKLAND, Mr. MEEHAN, Mrs. NAPOLITANO, Mr. MASCARA, Mr. NEAL of Massachusetts, Mr. HINOJOSA, Mr. BOUCHER, Mr. SHERMAN, Ms. DELAURO, Mr. WYNN, Ms. KILPATRICK, Mr. MOLLOHAN, Mr. UDALL of New Mexico, Mr. FILNER, Mr. FALEOMAVAEGA, Mr. COYNE, Ms. HOOLEY of Oregon, Mr. FROST, Mr. LEWIS of Georgia, Mr. RAHALL, Mr. MORAN of Virginia, Mr. OBERSTAR, Mr. WEXLER, Mr. BECERRA, Mr. RODRIGUEZ, Mr. KIND, Ms. SLAUGHTER, Mr. UNDERWOOD, Mr. BERMAN, Ms. BALDWIN, Ms. CARSON of Indiana, Mrs. TAUSCHER, Mr. STUPAK, Mr. EHRLICH, and Mr. ENGLISH) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To authorize the Secretary of Veterans Affairs to award grants to provide for a national toll-free hotline to provide information and assistance to veterans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Veterans' Emergency
3 Telephone Service Act of 2001".

4 **SEC. 2. NATIONAL VETERANS ASSISTANCE HOTLINE**
5 **GRANT.**

6 (a) AUTHORITY TO AWARD GRANTS.—The Secretary
7 of Veterans Affairs may award a grant to a private, non-
8 profit entity to provide for the operation of a national, toll-
9 free telephone hotline to provide information and assist-
10 ance to veterans and their families, including crisis inter-
11 vention counseling, general information with respect to
12 veterans benefits under title 38, United States Code, refer-
13 rals to appropriate individuals with expertise in such vet-
14 erans benefits, and information with respect to the provi-
15 sion of emergency shelter and food, substance abuse reha-
16 bilitation, employment training and opportunities, and
17 small business assistance programs.

18 (b) DURATION.—A grant under this section may ex-
19 tend over a period of not more than two years.

20 (c) ANNUAL APPROVAL.—The provision of payments
21 under a grant under this section shall be subject to annual
22 approval by the Secretary and subject to the availability
23 of appropriations for each fiscal year to make the pay-
24 ments.

25 (d) ACTIVITIES.—Funds received by an entity under
26 this section shall be used to establish and operate a na-

1 tional, toll-free telephone hotline to provide information
2 and assistance to veterans. In establishing and operating
3 the hotline, a private, nonprofit entity shall—
4 (1) contract with a carrier for the use of a toll-
5 free telephone line;
6 (2) employ, train, and supervise personnel to
7 answer incoming calls and provide counseling and
8 referral services to callers on a 24-hour-a-day basis;
9 (3) assemble and maintain a current database
10 of information relating to services for veterans to
11 which callers may be referred throughout the United
12 States; and
13 (4) publicize the hotline to potential users
14 throughout the United States.
15 (e) APPLICATION.—A grant may not be made under
16 this section unless an application for such grant has been
17 approved by the Secretary. To be approved by the Sec-
18 retary under this subsection an application shall—
19 (1) contain such agreements, assurances, and
20 information, be in such form and be submitted in
21 such manner as the Secretary shall prescribe
22 through notice in the Federal Register;
23 (2) include a complete description of the appli-
24 cant's plan for the operation of a national veterans
25 assistance hotline grant, including descriptions of—

1 (A) the training program for hotline per-
2 sonnel;
3 (B) the hiring criteria for hotline per-
4 sonnel;
5 (C) the methods for the creation, mainte-
6 nance and updating of a resource database;
7 (D) a plan for publicizing the availability
8 of the hotline;
9 (E) a plan for providing service to non-
10 English speaking callers, including hotline per-
11 sonnel who speak Spanish; and
12 (F) a plan for facilitating access to the
13 hotline by persons with hearing impairments;
14 (3) demonstrate that the applicant has nation-
15 ally recognized expertise in the area of furnishing
16 assistance to veterans and a record of high quality
17 service in furnishing such assistance, including a
18 demonstration of support from advocacy groups,
19 such as Veterans Service Organizations; and
20 (4) contain such other information as the Sec-
21 retary may require.
22 (f) AUTHORIZATION OF APPROPRIATIONS.—
23 (1) IN GENERAL.—There are authorized to be
24 appropriated to carry out this section $2,000,000 for
25 each of fiscal years 2002 and 2003.

1 (2) AVAILABILITY.—Funds authorized to be ap-
2 propriated under paragraph (1) shall remain avail-
3 able until expended.

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107TH CONGRESS
1ST SESSION

H. R. 1746

To amend title 38, United States Code, to require that the Secretary of Veterans Affairs establish a single "1–800" telephone number for access by the public to veterans benefits counselors of the Department of Veterans Affairs and to ensure that such counselors have available to them information about veterans benefits provided by all Federal departments and agencies and by State governments.

IN THE HOUSE OF REPRESENTATIVES

MAY 8, 2001

Mr. BAKER (for himself, Mr. SIMMONS, and Mr. SMITH of New Jersey) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to require that the Secretary of Veterans Affairs establish a single "1–800" telephone number for access by the public to veterans benefits counselors of the Department of Veterans Affairs and to ensure that such counselors have available to them information about veterans benefits provided by all Federal departments and agencies and by State governments.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 That section 7723 of title 38, United States Code, is
2 amended by adding at the end the following new sub-
3 section:

4 "(c)(1) The Secretary shall provide for a single toll-
5 free (so-called '1–800') telephone number to be available
6 for access by the public to veterans benefits counselors of
7 the Department.

8 "(2) The Secretary shall ensure that (in addition to
9 information about benefits provided under laws adminis-
10 tered by the Secretary) veterans benefits counselors of the
11 Department have available to them information about vet-
12 erans benefits provided by—

13 "(A) all other departments and agencies of the
14 United States and

15 "(B) State governments.

16 "(3) For purposes of this subsection, the term 'vet-
17 erans benefits' means benefits provided to persons based
18 upon their own service or the service of someone else in
19 the Armed Forces.".

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107TH CONGRESS
1ST SESSION

H. R. 1929

To amend title 38, United States Code, to extend the Native American veteran housing loan pilot program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 21, 2001

Mr. UDALL of New Mexico (for himself, Mr. EVANS, Mr. ABERCROMBIE, Mr. JEFFERSON, Mr. KENNEDY of Rhode Island, Mr. BONIOR, Mr. CARSON of Oklahoma, Mr. BACA, Ms. BROWN of Florida, Mr. GEORGE MILLER of California, Mr. FILNER, Mr. PALLONE, Mr. UDALL of Colorado, Ms. PELOSI, and Mr. CONDIT) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend the Native American veteran housing loan pilot program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native American Veterans Home Loan Act of 2001".

1 **SEC. 2. EXTENSION OF NATIVE AMERICAN VETERAN HOUS-**
2 **ING LOAN PILOT PROGRAM.**

3 Section 3761(c) of title 38, United States Code, is
4 amended by striking "2001" and inserting "2005".

5 **SEC. 3. AUTHORIZING THE USE OF CERTAIN FEDERAL**
6 **MEMORANDUMS OF UNDERSTANDING.**

7 Section 3762(a)(1) of title 38, United States Code,
8 is amended—

9 (1) by inserting "(A)" after "(1)";

10 (2) by striking "; and" and inserting "; or";
11 and

12 (3) by adding at the end the following:

13 "(B) the tribal organization that has jurisdic-
14 tion over the veteran has entered into a memo-
15 randum of understanding with any department or
16 agency of the United States with respect to direct
17 housing loans to Native Americans that Secretary
18 determines substantially complies with the require-
19 ments of subsection (b); and".

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107TH CONGRESS
1ST SESSION

H. R. 2359

To amend title 38, United States Code, to authorize the payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veteran housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims.

IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2001

Mr. SMITH of New Jersey (for himself and Mr. EVANS) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize the payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veteran housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. PAYMENT OF INSURANCE PROCEEDS TO AN AL-**
2 **TERNATE BENEFICIARY WHEN FIRST BENE-**
3 **FICIARY CANNOT BE IDENTIFIED.**

4 (a) NSLI.—Section 1917 of title 38, United States
5 Code, is amended by adding at the end the following new
6 subsection:

7 "(f)(1) Following the death of the insured—

8 "(A) if the first beneficiary otherwise entitled to
9 payment of the insurance proceeds does not make a
10 claim for such payment within two years after the
11 death of the insured, payment of the proceeds may
12 be made to another beneficiary designated by the in-
13 sured, in the order of precedence as designated by
14 the insured, as if the first beneficiary had pre-
15 deceased the insured; and

16 "(B) if within four years after the death of the
17 insured, no claim has been filed by a person des-
18 ignated by the insured as a beneficiary and the Sec-
19 retary has not received any notice in writing that
20 any such claim will be made, payment of the insur-
21 ance proceeds may (notwithstanding any other provi-
22 sion of law) be made to such person as may in the
23 judgment of the Secretary be equitably entitled to
24 the proceeds of the policy.

25 "(2) Payment of insurance proceeds under paragraph
26 (1) shall be a bar to recovery by any other person.".

1 (b) USGLI.—Section 1951 of such title is
2 amended—
3 (1) by inserting "(a)" before "United States
4 Government"; and
5 (2) by adding at the end the following new sub-
6 section:
7 "(b)(1) Following the death of the insured—
8 "(A) if the first beneficiary otherwise entitled to
9 payment of the insurance proceeds does not make a
10 claim for such payment within two years after the
11 death of the insured, payment of the proceeds may
12 be made to another beneficiary designated by the in-
13 sured, in the order of precedence as designated by
14 the insured, as if the first beneficiary had pre-
15 deceased the insured; and
16 "(B) if within four years after the death of the
17 insured, no claim has been filed by a person des-
18 ignated by the insured as a beneficiary and the Sec-
19 retary has not received any notice in writing that
20 any such claim will be made, payment of the insur-
21 ance proceeds may (notwithstanding any other provi-
22 sion of law) be made to such person as may in the
23 judgment of the Secretary be equitably entitled to
24 the proceeds of the policy.

1 "(2) Payment of insurance proceeds under paragraph
2 (1) shall be a bar to recovery by any other person.".
3 (c) TRANSITION PROVISION.—In the case of a person
4 insured under subchapter I or II of chapter 19 of title
5 38, United States Code, who dies before the date of the
6 enactment of this Act, the two-year and four-year periods
7 specified in subsection (f)(1) of section 1917 of title 38,
8 United States Code, as added by subsection (a), and sub-
9 section (b)(1) of section 1951 of such title, as added by
10 subsection (b), shall for purposes of the applicable sub-
11 section be treated as being the two-year and four-year pe-
12 riods, respectively, beginning on the date of the enactment
13 of this Act.

14 **SEC. 2. NATIVE AMERICAN VETERAN HOUSING LOAN PILOT**
15 **PROGRAM.**

16 (a) EXTENSION OF NATIVE AMERICAN VETERAN
17 HOUSING LOAN PILOT PROGRAM.—Section 3761(c) of
18 title 38, United States Code, is amended by striking
19 "2001" and inserting "2005".
20 (b) AUTHORIZATION OF THE USE OF CERTAIN FED-
21 ERAL MEMORANDUMS OF UNDERSTANDING.—Section
22 3762(a)(1) of such title is amended—
23 (1) by inserting "(A)" after "(1)";
24 (2) by striking "and" after the semicolon and
25 inserting "or"; and

1 (3) by adding at the end the following:

2 "(B) the tribal organization that has jurisdic-
3 tion over the veteran has entered into a memo-
4 randum of understanding with any department or
5 agency of the United States with respect to direct
6 housing loans to Native Americans that the Sec-
7 retary determines—

8 "(i) contemplates loans made under this
9 subchapter; and

10 "(ii) substantially complies with the re-
11 quirements of subsection (b); and".

12 (c) MODIFICATION OF LOAN ASSUMPTION NOTICE
13 REQUIREMENT.—Section 3714(d) of such title is amended
14 to read as follows:

15 "(d) With respect to a loan guaranteed, insured, or
16 made under this chapter, the Secretary shall provide, by
17 regulation, that at least one instrument evidencing either
18 the loan or the mortgage or deed of trust therefor, shall
19 conspicuously contain, in such form as the Secretary shall
20 specify, a notice in substantially the following form: 'This
21 loan is not assumable without the approval of the Depart-
22 ment of Veterans Affairs or its authorized agent'.".

SEC. 3. ELIMINATION OF REQUIREMENT FOR PROVIDING A COPY OF NOTICE OF APPEAL TO THE SECRETARY.

(a) REPEAL.—Section 7266 of title 38, United States Code, is amended by striking subsection (b).

(b) CONFORMING AMENDMENTS.—Such section is further amended—

(1) by striking "(1)" after "(a)";

(2) by redesignating paragraph (2) as subsection (b);

(3) by redesignating paragraph (3) as subsection (c) and redesignating subparagraphs (A) and (B) thereof as paragraphs (1) and (2); and

(4) by redesignating paragraph (4) as subsection (d) and by striking "paragraph (3)(B)" therein and inserting "subsection (c)(2)".

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107TH CONGRESS
1ST SESSION

H. R. 2361

To increase, effective as of December 1, 2001, the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain service-connected disabled veterans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2001

Mr. SMITH of New Jersey (for himself, Mr. EVANS, Mr. SIMPSON, Mr. REYES, and Mr. SPENCE) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To increase, effective as of December 1, 2001, the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain service-connected disabled veterans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Veterans' Compensa-
5 tion Cost-of-Living Adjustment Act of 2001".

1 **SEC. 2. INCREASE IN RATES OF DISABILITY COMPENSA-**
2 **TION AND DEPENDENCY AND INDEMNITY**
3 **COMPENSATION.**

4 (a) RATE ADJUSTMENT.—The Secretary of Veterans
5 Affairs shall, effective on December 1, 2001, increase the
6 dollar amounts in effect for the payment of disability com-
7 pensation and dependency and indemnity compensation by
8 the Secretary, as specified in subsection (b).

9 (b) AMOUNTS TO BE INCREASED.—The dollar
10 amounts to be increased pursuant to subsection (a) are
11 the following:

12 (1) COMPENSATION.—Each of the dollar
13 amounts in effect under section 1114 of title 38,
14 United States Code.

15 (2) ADDITIONAL COMPENSATION FOR DEPEND-
16 ENTS.—Each of the dollar amounts in effect under
17 sections 1115(1) of such title.

18 (3) CLOTHING ALLOWANCE.—The dollar
19 amount in effect under section 1162 of such title.

20 (4) NEW DIC RATES.—The dollar amounts in
21 effect under paragraphs (1) and (2) of section
22 1311(a) of such title.

23 (5) OLD DIC RATES.—Each of the dollar
24 amounts in effect under section 1311(a)(3) of such
25 title.

1 (6) ADDITIONAL DIC FOR SURVIVING SPOUSES
2 WITH MINOR CHILDREN.—The dollar amount in ef-
3 fect under section 1311(b) of such title.
4 (7) ADDITIONAL DIC FOR DISABILITY.—The
5 dollar amounts in effect under sections 1311(c) and
6 1311(d) of such title.
7 (8) DIC FOR DEPENDENT CHILDREN.—The
8 dollar amounts in effect under sections 1313(a) and
9 1314 of such title.
10 (c) DETERMINATION OF INCREASE.—(1) The in-
11 crease under subsection (a) shall be made in the dollar
12 amounts specified in subsection (b) as in effect on Novem-
13 ber 30, 2001.
14 (2) Except as provided in paragraph (3), each such
15 amount shall be increased by the same percentage as the
16 percentage by which benefit amounts payable under title
17 II of the Social Security Act (42 U.S.C. 401 et seq.) are
18 increased effective December 1, 2001, as a result of a de-
19 termination under section 215(i) of such Act (42 U.S.C.
20 415(i)).
21 (3) Each dollar amount increased pursuant to para-
22 graph (2) shall, if not a whole dollar amount, be rounded
23 down to the next lower whole dollar amount.
24 (d) SPECIAL RULE.—The Secretary may adjust ad-
25 ministratively, consistent with the increases made under

1 subsection (a), the rates of disability compensation pay-
2 able to persons within the purview of section 10 of Public
3 Law 85–857 (72 Stat. 1263) who are not in receipt of
4 compensation payable pursuant to chapter 11 of title 38,
5 United States Code.

6 **SEC. 3. PUBLICATION OF ADJUSTED RATES.**

7 At the same time as the matters specified in section
8 215(i)(2)(D) of the Social Security Act (42 U.S.C.
9 415(i)(2)(D)) are required to be published by reason of
10 a determination made under section 215(i) of such Act
11 during fiscal year 2002, the Secretary of Veterans Affairs
12 shall publish in the Federal Register the amounts specified
13 in subsection (b) of section 2, as increased pursuant to
14 that section.

○

OPENING STATEMENT
HONORABLE SILVESTRE REYES, RANKING DEMOCRATIC MEMBER, SUBCOMMITTEE ON BENEFITS
HEARING ON HR 862, HR 1406, HR 1435, HR 1746, HR 1929, HR 2359 AND HR 2361
JULY 10, 2001

I would like to take this opportunity to welcome Mike Simpson as the new Chairman of our Subcommittee. I look forward to working with you to improve the lives of our Nation's veterans. I also welcome the Members who will be testifying today, Mr. Udall and Mr. Manzullo.

As an original cosponsor and strong supporter of a number of the bills being heard today, I am pleased that we are holding this hearing.

I support including Diabetes Mellitus, Type 2 as a statutory presumption for veterans exposed to Agent Orange. While I congratulate the Secretary of Veterans Affairs for his prompt action in providing a presumption for diabetes in regulation, I believe that

we should provide veterans with a statutory presumption.

I also strongly support H.R. 1406. Both Bob Stump, the former Chairman of the Full Committee, and Lane Evans, our Democratic Ranking Member, have criticized VA's unduly restrictive interpretation of the definition of "undiagnosed illness." This statutory change is essential to stop the practice of making different determinations of eligibility for compensation benefits depending on whether a set of symptoms is attributable to an "undiagnosed" or "poorly defined" condition.

I recognize that the ill-defined nature of many of the symptoms experienced by Gulf War veterans have led some to conclude that the presumptive period for manifestation of undiagnosed illnesses should be extended beyond December 31, 2001. Most of the veterans' filing claims for undiagnosed illness are veterans who served in the Gulf during the actual conflict. I am not aware of any veterans who recently began experiencing symptoms of poorly defined illnesses many years after leaving the Gulf and am, therefore, reluctant to support extending the presumption for all veterans for another ten years. However, based on the slow development of

symptoms after veterans leave the Gulf, I would ask VA and the veterans service organizations to comment on the desirability of providing veterans who have served or serve in the Gulf a ten year presumption for service-connection after their last period of service in the Gulf. I also strongly support the provision to protect veterans participating in VA-sponsored medical research from loss of benefits.

I understand the main purpose of H.R. 1435, the Veterans' Emergency Telephone Service Act, is to provide crisis intervention and information and referral services to veterans needing immediate assistance. The object of this program would not be to duplicate services provided by VA's current toll free numbers, but to provide an immediate resource for veterans experiencing a crisis situation.

The issues raised by H.R. 1746 as well as H.R. 1435 indicate to me that VA's current 1-800 numbers are not working as well as should be expected. According to research by Committee staff, veterans can wait for almost one-half hour to have their calls answered. I would also like to hear from VA concerning the training and information provided to personnel staffing these numbers. In some instances, incomplete or incorrect information was provided.

I, furthermore, fully support H.R. 1929 which would extend and improve the Native American Home Loan pilot project. I thank the gentleman from New Mexico for bringing this matter to the attention of the Committee. It is my understanding that the outreach provisions which VA would like removed are essential to the successful operation of this program. I would, therefore, propose that we reject VA's request.

I support H.R. 2359 which includes a provision for allowing payment of life insurance proceeds which VA has been maintaining due to the inability to locate named beneficiaries. This provision is similar to a provision contained in H.R. 2222, the Veterans Life Insurance Improvement Act of 2001, introduced by Representative Bob Filner which would allow the VA to pay over 4,000 claims for which the primary and/or secondary beneficiary cannot be found. I would hope that we could eventually consider the other important provisions contained within H.R. 2222. I am also a supporter of the provision in H.R. 2359, which is similar to the Udall/Evans bill, H.R. 1929. I as well support the elimination of the requirement for veterans appealing to the Court to notify the Secretary of their appeal.

I support providing a cost of living increase comparable to that provided to Social Security beneficiaries. Benefits provided to our Nation's veterans and their families should never be eroded by increases in the cost of living.

I thank the witnesses for testifying and look forward to your testimony.

OPENING STATEMENT
HONORABLE LANE EVANS,
RANKING DEMOCRATIC MEMBER
HEARING ON HR 862, HR 1406, HR 1435, HR 1746,
HR 1929, HR 2359 AND HR 2361
JULY 10, 2001

Mr. Simpson, I join with other Members in wishing you well as you assume the responsibilities of Chairman of the Subcommittee on Benefits. I look forward to working with you on behalf of all veterans. I also welcome the Members who will be testifying today, Tom Udall and Don Manzullo.

The Subcommittee will receive testimony today on a number of bills. I welcome VA's recent regulation providing a presumption of service-connection for veterans exposed to dioxin who now suffer from Diabetes Mellitus, Type 2. This was the right action to take. Now it is time to provide a statutory presumption that makes it clear to veterans that their eligibility is protected as a matter of law. Passage of H.R. 862 will accomplish this. This important step will not result in any additional benefit costs, but will assure our Nation's veterans of their statutory right. I also hope that the Committee will take up H.R. 1578 which will eliminate the arbitrary time limit on claims related to respiratory cancers due to exposure to Agent Orange. The same National Academy of Science report which supports service-connection for diabetes, also reported that there was no scientific basis for the 30-year limitation for respiratory cancers in current law.

I also strongly support H.R. 1406. As many of the veterans organizations have noted, both Bob Stump, former the Chairman of this Committee, and I have criticized VA's interpretation of the term "undiagnosed Illness" in VA General Counsel Precedent Opinion 8-98 as extremely restrictive. My proposal is intended to reverse that opinion and prevent VA from denying claims of disabled veterans on the basis that their symptoms are due to such vaguely defined illnesses as fibromyalgia and chronic fatigue syndrome. Since there is no know cause for these illnesses, as a practical matter VA's ability to provide compensation is meaningless for any veteran whose symptoms were not manifest during active duty.

The provision would also apply to disabilities resulting from what is increasingly referred to in the medical research as "chronic multisymptom illnesses". (See, "Chronic Multisymptom Illness Affecting Air Force Veterans of the Gulf War", Fukuda et al, *JAMA* 1988; 280:981-988, "Clinical Risk Communication: Explaining Causality To Gulf War Veterans With Chronic Multisymptom Illnesses" Engel, Sunrise Symposium (June 25, 1999) (Found at www.deploymenthealth.mil/ education/risk_comm.doc.) and "Multiple Chemical Sensitivity and Chronic Fatigue Syndrome in British Gulf War Veterans", Reid et al, *American Journal of Epidemiology*, 2001 153:604-609.

The handling of claims based on undiagnosed illnesses continues to be problematic. Cases continue to be brought to my attention where VA physicians have affirmatively stated some symptoms may be attributable to a diagnosis while others are not consistent with a known diagnosis. Recently, VA denied a veteran's claim for benefits for an undiagnosed illness despite affirmative VA medical opinions that the undiagnosed symptoms were not characteristic of another diagnosed condition. Nonetheless, the veteran's claim was denied on the basis that all symptoms were due to the diagnosed condition. Veterans must be provided the benefit of the doubt. VA's cost estimate for compensating Gulf veterans who suffer from fibromyalgia and chronic fatigue syndrome is evidence that such claims are being denied under present law.

I understand the concerns raised by those who believe that the presumptive period for undiagnosed illnesses should be extended. Except for members of the Guard and Reserve who, though not assigned to the Gulf have suffered adverse effects following the administration of anthrax and other vaccines while on inactive duty for training, I am not aware of any cases where symptoms of undiagnosed illnesses have recently become manifest. I am also not aware of any servicemembers recently assigned to the Gulf having experienced symptoms of undiagnosed illnesses, chronic fatigue syndrome or fibromyalgia. If there is evidence that servicemembers who recently served in the Gulf are manifesting such symptoms, I urge the Department of Veterans Affairs to provide an extension of the presumption so that more recently separated veterans would receive a ten year presumptive period following their last service in the Southwest Asia theater of operations like veterans who served during the Conflict. Although I hope that no disabilities with a long latency period such as cancer or other

illnesses will result from Gulf Service, I believe that we should consider presumptions of service-connection if and when certain disabilities are determined to be more prevalent in Gulf veterans than comparable populations.

I also share concerns addressed in legislation proposed by Ms. Capps and Mr. Baker concerning VA's toll-free telephone service. My staff recently called the 1-800-827-1000 number on different days at different times. The length of time on hold ranged from 7 minutes to 25 minutes with most calls taking 10 minutes to answer. While VA employees were polite and attempted to be helpful, not all of the answers received were correct or complete. This suggests that the current system may not be adequately staffed to meet the needs of our Nation's veterans and alternatives should be explored.

It is not clear to me that any VA telephone number in current use, addresses the crisis intervention needs of our most vulnerable veterans, which H.R. 1546 proposes to address. Veterans who are homeless or experiencing a severe financial, mental or physical health crisis could benefit from services such as those provided on a limited scale by the National Veterans Foundation.

I strongly support the provisions contained in H.R. 1929 introduced by Tom Udall and myself. I am pleased that VA is supporting this measure. It is my understanding that earlier during this fiscal year, 15 home loans under the pilot program were delayed for almost six months because funding for necessary outreach services had not been provided to the Honolulu Regional Office. It is critical that this Congress continues to recognize the important differences between homes on tribal land and conventional home loans. The outreach provisions in current law must be continued to assure that the loans needed by Native American veterans can actually be made in areas where Anglo-American legal principles of real property do not exist. I urge the Committee to reject VA's proposal to eliminate outreach services.

I support the provisions of H.R. 2359 which includes a provision similar to that contained in H.R. 2222 introduced by Mr.Filner, a Member of this Committee. VA should not be holding monies which could be distributed to the rightful beneficiaries or heirs of a veteran when the primary beneficiary can not be located. I am also concerned to learn that

some monies which has not been paid to beneficiaries has been included as surplus monies available for distribution. We should make every effort to assure that the rightful or equitable owners of these interests receive the funds to which they are entitled.

As noted above, I support the provisions in section 2 of the bill which mirror the provisions of H.R. 1929. I also support the additional provision which would allow changes in the assumption notice for all VA loans and is not limited to the Native American pilot project.

Finally, I support the change recommended by section 3 to eliminate the requirement that veterans filing an appeal with the court also notify the VA. This requirement has apparently caused confusion among appellants and caused some to be denied their right to appeal a decision to the court in a timely manner. Since current court rules require the U.S. Court of Appeals for Veterans Claims to notify the Secretary of Veterans Affairs when the appeal is documented, sufficient notice would be provided to the Secretary if this requirement were eliminated.

Finally, I fully support the cost-of-living increase proposed by H.R. 2361. Our veterans must never lose the purchasing power of their earned benefits because basic living expenses have increased. Our Nation's veterans have earned their benefits. It is the obligation of a grateful Nation to preserve the purchasing power of these benefits and pay them in a timely manner.

I thank the Chairman and Ranking Member of the Subcommittee for holding this hearing and the witnesses for appearing today.

Testimony of Congressman Donald Manzullo (R-IL)
before the House Veterans' Affairs Subcommittee on Benefits
Tuesday, July 10, 2001

Chairman Simpson and Members of the Subcommittee, thank you for the opportunity to testify on behalf of legislation I introduced with Mr. Gallegly and Mr. Shows: H.R. 612, the *Persian Gulf War Illness Compensation Act of 2001* (Exhibit A).

Ten years ago, a patriot from Freeport, Illinois, named Dan Steele went off to war in Iraq to protect the freedoms this country has known for more than 200 years. During the buildup in the Gulf, Dan's leg was fractured by an Iraqi soldier's apparent suicide attack. Over the next eight years, Dan suffered from various conditions shared by many other soldiers who fought in the Gulf War.

In May 1999, Dan succumbed to his illnesses and passed away. The county coroner listed "Gulf War Syndrome" as a secondary cause of death on his death certificate. Shortly after Dan's funeral, I contacted his widow, Donna. She vowed to Dan that she would do whatever she could so that this would not happen to other veterans. Her story moved me to introduce legislation to compensate our suffering Gulf War veterans.

H.R. 612 is a simple, technical correction of the *undiagnosed illness compensation* law Congress passed in 1994, Public Law 103-446. Congress enacted P.L. 103-446 to ensure compensation for Gulf War veterans suffering from unexplained conditions commonly referred to as "Gulf War Illness." Unfortunately,.three-quarters of the veterans who have applied for this compensation have been denied because the Department of Veteran's Affairs is implementing the law too narrowly. To solve this problem, H.R. 612 clarifies the standards for compensation for Gulf War veterans suffering from certain undiagnosed illnesses by defining the term "undiagnosed illness" and extends the presumptive period for undiagnosed illness claims.

The problem with the undiagnosed illness compensation program is not new to the House Veterans' Affairs Committee.

On June 3, 1998, Chairman Bob Stump wrote to Secretary Togo West to protest the VA's narrow implementation of the law and request a review of the VA's regulations (Exhibit B). H.R. 612 incorporates Chairman Stump's statement of the intent of Congress. **Stump's problem with the VA is that once the VA diagnosed a veteran with a poorly defined illness, then the veteran could no longer receive compensation for an "undiagnosed illness."** Stump added that this practice "frustrate[s] the purposes of this law, and ...raise[s] a serious question of deprivation of due process" under the Constitution.

The VA's response to Chairman Stump's letter was to issue a confusing and complicated legal opinion (Exhibit C). I have come to the conclusion that the VA is denying compensation based

on the fact that the veteran can't show the cause of his or her malady, and once a veteran is diagnosed with an illness, even a poorly defined illness, he or she cannot be compensated under P.L. 103-446. The only thing this legal opinion indicates is that the VA needs specific direction and language from Congress, in addition to that very specific language Congress set forth in 1994. ***The VA does not understand Congress' intention as set forth in the 1994 law. Congress simply wanted to make sure that Gulf War veterans who went off to war and returned with illnesses whose cause cannot be explained should be compensated. Period.*** That is why I introduced H.R. 612, which Sen. Kay Bailey Hutchison also introduced as S. 409.

Two weeks ago, the VA again demonstrated that it does not understand Congress' intention. On June 28, Deputy Secretary of Veterans Affairs Leo S. Mackay, Jr. testified before the Senate VA Committee on S. 409 that the VA already has the authority to compensate Gulf War Veterans adequately. If so, then why is the VA fighting these veterans?

H.R. 612 also extends by ten years the presumptive period for undiagnosed illness claims. As you know, this time period is set to expire at the end of this year. To date, Gulf War-related research remains inconclusive and unclear after the U.S. Government has spent over $150 million on countless studies. In fact, Congress has requested a series of Gulf War-related reports from the Institute of Medicine over the next several years. In the face of such uncertainty, it only makes sense to extend the presumptive period.

There is adequate funding available to implement H.R. 612. A cost analysis by my office estimates that bill will require approximately $80 million per year in each of the first two years after enactment, and $30 million per year thereafter. President Bush's budget for fiscal year 2002 increases compensation funding for Persian Gulf veterans by $437 million (Exhibit D). Furthermore, the Congressional Budget Resolution for Fiscal Year 2002 increases mandatory spending for veterans by $3.9 billion. A large portion of this increase will go to enhanced benefits, such as the new and improved GI Bill. However, there is a substantial amount left over to pay for the reforms of H.R. 612.

Finally, H.R. 612 includes retroactive payment provisions so that the veterans who were denied benefits payments by the VA in the past can be properly compensated. Representatives Gallegly, Shows and I believe this is simply a matter of fairness.

In November 1999, candidate George W. Bush made the following statement in his Veterans' Day speech:

> "Veterans need advocates in the Veterans Administration, people sympathetic to their interests instead of suspicious. If I am elected, that is the kind of veterans official I intend to appoint.
>
> "This applies to veterans of the Gulf War, too. They should not have to go to elaborate lengths to prove that they are ill, just because their malady has yet to be fully explained.

"A 1994 law was passed to grant them the presumption of disability. Yet even now they are met with skeptical looks and paper-shuffling excuses for withholding coverage.

"If I have anything to say about it, all that is going to end. In the military, when you are called to account for a mistake, you are expected to give one simple answer: 'No excuse, sir.'"

Mr. Chairman, why is the VA fighting the President, Congress and the veterans?

H.R. 612 is the solution to the problem outlined by President Bush and the VA Committee. This bill has the support of 221 Members of the House and all the major veterans' groups.

Mr. Evans' bill, H.R. 1406, Section 2, fills in **some** of the gaps caused by the VA's misinterpretation of the 1994 law by stating that a veteran is entitled to disability if he or she has been diagnosed with certain ill-defined illnesses. Our bill completes and clarifies Mr. Evans' bill by defining undiagnosed illnesses so that our veterans will never again have to fight the VA to get the compensation they deserve and we owe them. I suggest we replace Section 2 of H.R. 1406 with H.R. 612 in its entirety. I believe Section 3 of H.R. 1406, of course, should be maintained. Or, you could mark up Mr. Evans' bill, minus Section 2, and also mark up H.R. 612 in its entirety.

Mr. Chairman, thank you again for this opportunity to testify. I would be happy to answer any questions.

107TH CONGRESS
1ST SESSION

H. R. 612

To amend title 38, United States Code, to clarify the standards for compensation for Persian Gulf veterans suffering from certain undiagnosed illnesses, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 14, 2001

Mr. MANZULLO (for himself, Mr. GALLEGLY, and Mr. SHOWS) introduced the following bill; which was referred to the Committee on Veterans Affairs

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A BILL

To amend title 38, United States Code, to clarify the standards for compensation for Persian Gulf veterans suffering from certain undiagnosed illnesses, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Persian Gulf War Illness Compensation Act of 2001".

SEC. 2. FINDINGS.

Congress makes the following findings:

1 (1) Although the majority of veterans of the
2 Armed Forces who served in the Persian Gulf War
3 returned from the Southwest Asia theater of oper-
4 ations to normal activities, many of those veterans
5 have experienced a range of unexplained illnesses,
6 including chronic fatigue, muscle and joint pain, loss
7 of concentration, forgetfulness, headache, and rash.
8 (2) Those veterans were potentially exposed to
9 a wide range of biological and chemical agents in-
10 cluding sand, smoke from oil-well fires, paints, sol-
11 vents, insecticides, petroleum fuels and their com-
12 bustion products, organophosphate nerve agents,
13 pyridostigmine bromide, depleted uranium, anthrax
14 and botulinum toxoid vaccinations, and infectious
15 diseases, in addition to other psychological and phys-
16 iological stresses.
17 (3) Section 1117 of title 38, United States
18 Code, enacted on November 2, 1994, by the Persian
19 Gulf War Veterans' Benefits Act (title I of Public
20 Law 103–446), provides for the payment of com-
21 pensation to Persian Gulf veterans suffering from a
22 chronic disability resulting from an undiagnosed ill-
23 ness (or combination of undiagnosed illnesses) that
24 became manifest to a compensable degree within a
25 period prescribed by regulation.

1 (4) The Secretary of Veterans Affairs pre-
2 scribed regulations under section 1117 of title 38,
3 United States Code, that interpreted that section so
4 as to limit compensation to Persian Gulf veterans
5 with illnesses that "cannot be attributed to any
6 known clinical diagnosis".

7 (5) In a report dated September 7, 2000, the
8 Institute of Medicine of the National Academy of
9 Sciences indicated that it was not asked to deter-
10 mine whether an identifiable medical syndrome re-
11 ferred to as "Gulf War Syndrome" exists and sug-
12 gested that the Secretary of Veterans Affairs, in de-
13 veloping a compensation program for Persian Gulf
14 veterans, consider the health effects that may be as-
15 sociated with exposures to specific agents that were
16 present in the Southwest Asia theater of operations
17 during the Persian Gulf War.

18 **SEC. 3. COMPENSATION OF VETERANS OF PERSIAN GULF**
19 **WAR WHO HAVE CERTAIN ILLNESSES.**

20 (a) PRESUMPTIVE PERIOD FOR UNDIAGNOSED ILL-
21 NESSES PROGRAM.—Section 1117 of title 38, United
22 States Code, is amended—

23 (1) in subsection (a)(2), by striking "within the
24 presumptive period prescribed under subsection (b)"
25 and inserting "before December 31, 2011, or such

1 later date as the Secretary may prescribe by regula-
2 tion"; and
3 (2) by striking subsection (b).
4 (b) UNDIAGNOSED ILLNESSES.—Such section, as
5 amended by subsection (a), is further amended by insert-
6 ing after subsection (a) the following new subsection (b):
7 "(b)(1) For purposes of this section, the term
8 'undiagnosed illness' means illness manifested by symp-
9 toms or signs the cause, etiology, or origin of which cannot
10 be specifically and definitely identified, including poorly
11 defined illnesses such as fibromyalgia, chronic fatigue syn-
12 drome, autoimmune disorder, and multiple chemical sensi-
13 tivity. The attribution of one or more of the symptoms
14 to a disability that is not an undiagnosed illness shall not
15 preclude other symptoms from being considered a mani-
16 festation of an undiagnosed illness.
17 "(2) For purposes of paragraph (1), signs or symp-
18 toms that may be a manifestation of an undiagnosed ill-
19 ness include the following:
20 "(A) Fatigue.
21 "(B) Unexplained rashes or other dermato-
22 logical signs or symptoms.
23 "(C) Headache.
24 "(D) Muscle pain.
25 "(E) Joint pain.

1 "(F) Neurologic signs or symptoms.

2 "(G) Neuropsychological signs or symptoms.

3 "(H) Signs or symptoms involving the res-
4 piratory system (upper or lower).

5 "(I) Sleep disturbances.

6 "(J) Gastrointestinal signs or symptoms.

7 "(K) Cardiovascular signs or symptoms.

8 "(L) Abnormal weight loss.

9 "(M) Menstrual disorders.".

10 (c) PRESUMPTION OF SERVICE CONNECTION PRO-
11 GRAM.—Section 1118(a) of such title is amended by add-
12 ing at the end the following new paragraph:

13 "(4) For purposes of this section, the term
14 'undiagnosed illness' has the meaning given that term in
15 section 1117(b) of this title.".

16 (d) EFFECTIVE DATE.—(1) For purposes of section
17 5110(g) of title 38, United States Code—

18 (A) the amendments to section 1117 of title 38,
19 United States Code, made by subsections (a) and (b)
20 shall take effect as of November 2, 1994; and

21 (B) the amendment to section 1118 of title 38,
22 United States Code, made by subsection (c) shall
23 take effect as of October 21, 1998.

24 (2) The second sentence of section 5110(g) of title
25 38, United States Code, shall not apply in the case of an

1 award, or increased award, of compensation pursuant to
2 the amendments made by this section if the date of appli-
3 cation therefor is not later than one year after the date
4 of the enactment of this Act.

○

ONE HUNDRED FIFTH CONGRESS

BOB STUMP
CHAIRMAN

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
335 CANNON HOUSE OFFICE BUILDING
Washington, DC 20515

B

5-
Persian Gulf file

June 3, 1998

Honorable Togo D. West, Jr.
Secretary of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, DC 20420

Dear Mr. Secretary:

As Congress continues to hear from Persian Gulf War veterans who believe their health care problems are of service origin, it has become increasingly apparent to us that the Department is too narrowly implementing the landmark legislation initiated in this Committee to provide compensation for these veterans.

The Persian Gulf War Veterans' Benefits Act (Public Law 103-446) in 1994, provided for the payment of compensation to Persian Gulf War veterans suffering from a chronic disability resulting from an undiagnosed illness (or combination of undiagnosed illnesses) which became manifest to a compensable degree within a period prescribed by regulation. VA regulations implementing that law, codified at 38 CFR section 3.317, effectively limit compensation to "illness...[which] by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis."

Neither the language of the law, nor its clear intent, compels so strict a limitation as that reflected above. I urge you to re-examine your authority under that law and amend this regulation in light of (1) the law's clear purpose, (2) what has been learned about Gulf War illnesses, and (3) the arbitrary and capricious results which flow from adjudications under this regulation. I believe such an analysis will lead you to conclude that the regulation should mandate compensation for illness manifested by symptoms which, after thorough examination, either (1) eludes diagnosis, or (2) if a diagnosis is rendered, attributes such symptoms to an ill-defined illness such as chronic fatigue syndrome or fibromyalgia.

Congress authorized compensation for certain chronic disabilities "resulting from an undiagnosed illness (or combination of undiagnosed illnesses)". One need not go beyond the face of the statute to question a regulation which in effect defines the term "undiagnosed illness" as one which cannot be attributed to any known clinical diagnosis. Literally, the regulation is so narrow as to rule out compensation even for an illness manifested by symptoms that could be attributed to a known diagnosis, even if no diagnosis is made. But to the extent that the Department reads the law as absolutely ruling out service-connection in any case in which a diagnosis has been made, it reads that law too narrowly.

Lest the intent of Congress in enacting the special compensation provision be thought in doubt, consider the congressional findings set forth in section 102 of the Act:

> "(2) Significant numbers of veterans of the Persian Gulf are suffering from illnesses, or are exhibiting symptoms of illness, that cannot now be diagnosed or clearly defined." (Emphasis added.)
>
> ***
>
> "(7) ...[V]eterans who are seriously ill as the result of such illnesses should be given the benefit of the doubt and be provided compensation benefits to offset the impairment in earnings capacities they may be experiencing."

As reflected in the above-quoted passages, and particularly the underscored phrase, Congress recognized that, because of the nature of the clusters of symptoms suffered by many Persian Gulf veterans, physicians were often either unable to identify and render a diagnosis, or faced an illness (or illnesses) which was not "clearly defined". Congress intended not only to provide a specific remedy, but signaled its intent that this new compensation policy be administered with the benefit of the doubt afforded the veteran. But in ruling out compensation under PL 103-446 in any case where the illness in question has been given a diagnosis is to ignore both the nature of the illnesses Congress sought to have VA compensate as well as the philosophy of benefits adjudication it sought to have the Department apply.

To illustrate, consider the case of two Persian Gulf War veterans who (1) have similar complaints (fatigue, difficulty in concentrating, musculo-skeletal pain, and gastro-intestinal problems); (2) first report these health care concerns three years after discharge from service; (3) provide similar in-theater histories as to Persian Gulf service; and (4) report "not feeling 100% after returning from the Gulf", suffering the above disabling

symptoms for more than a year, and being unable to work for the last six months. After similar workups, veteran #1, examined at VAMC X, is diagnosed with chronic fatigue syndrome and provided symptomatic treatment. Veteran #2, examined at VAMC Y, is not given a diagnosis, but is provided the same symptomatic treatment for an "illness of undefined nature". Both veterans file claims for compensation. Veteran #1 is denied service connection for chronic fatigue syndrome on the basis that there is no documentation of illness in service and insufficient continuity of symptoms after service; PL 103-446 is deemed not to apply because the veteran does not have an undiagnosed illness. Veteran #2 is granted service connection for his undiagnosed illness under PL 103-446.

While hypothetical in nature, this illustration represents an all-too-plausible snapshot of the arbitrary nature of adjudicative decision-making under the Department's regulation. As reflected in the above hypothetical, veterans become either beneficiaries or victims of a capricious system if they are awarded or denied service connection based on the happenstance of which VA physician happens to examine or treat them. Yet the regulation fosters such caprice when decisions turn on whether a physician, confronted by an ill-defined symptom complex, employs a diagnosis like chronic fatigue syndrome or fibromyalgia, or simply acknowledges his or her uncertainty regarding what is an ill-defined health problem.

What is clear with respect to such symptom complexes is that they are poorly understood. As described in expert testimony presented to our Subcommittee on Health from Dr. Daniel J. Clauw, Chief of Rheumatology, Immunology, and Allergy at Georgetown University Medical Center, at a June 19, 1997 hearing, quoted below, these are ill-defined illnesses, and the line between those cases which result in a diagnosis and those which do not is also a very fine one. It is also understandable that some physicians, untrained in the area, would not employ a diagnosis for a poorly understood symptom complex. Yet a diagnosis like fibromyalgia or chronic fatigue syndrome, as understood in the developing medical literature, identifies precisely the kind of symptoms which were reported by veterans after the Gulf War and which prompted the enactment of P.L. 103-446. Dr. Clauw's comments highlight the point:

> "I have been involved in both research and the clinical care of persons afflicted with a number of ill-defined and poorly understood medical conditions, which include fibromyalgia and chronic fatigue syndrome...[A]lthough these symptom complexes go by a variety of semantic terms, most involved in the study

of these conditions feel that these conditions are one large spectrum of illness. The symptoms and findings in individuals with the Persian Gulf Syndrome are the same as those of persons labeled with these other conditions, except that the Persian Gulf Syndrome patients developed these problems during or after deployment to the Gulf War. Why are these illnesses not recognized, and difficult to diagnose? One of the reasons for incomplete recognition of these conditions is that this symptom complex is given many different names, and many different attributions. Another reason is that there are no blood tests or other diagnostic studies that are predictably abnormal in persons with this illness. Because of this, these conditions are diagnosed on the basis of symptoms, and by excluding other medical problems which can cause the same type of symptoms. Another significant problem with the recognition and acceptance of fibromyalgia and related conditions is that these illnesses in general have become known as 'psychosomatic' conditions. *All of these conditions are either triggered or exacerbated by a variety of physical, immune, or emotional stressors, and there is likely a common underlying cause or causes for this entire spectrum of illness. Unfortunately, the root causes for this spectrum of illness are not presently known.*"

(The Institute of Medicine's discussion of difficult-to-diagnose and ill-defined conditions in its January 1998 report on the "Adequacy of the Comprehensive Clinical Evaluation Program" is also illuminating.)

Accordingly, for the Department to adjudicate cases on the basis of a rigid distinction between "diagnosed" and "undiagnosed" conditions is to ignore altogether what we have come to learn about chronic fatigue syndrome, fibromyalgia and related ill-defined conditions. Continued reliance on the current regulation ignores that medicine does not fully understand these ill-defined conditions and that physicians may or may not diagnose them. As is apparent from the literature on these illnesses, however, they present with many of the same symptoms which have been described in Persian Gulf veterans from the earliest reports and which were the subject of Congress' effort to service-connect veterans who suffer from symptoms of illness which cannot be clearly defined. Thus, for the regulation which implements PL 103-446 to effectively rule out service-connection under that law in any case in which a VA physician happens to assign a diagnostic label associated with an ill-defined illness is to frustrate the purposes of this law, and to raise a serious question of deprivation of due process.

I trust you will carefully consider these concerns in reviewing the applicable VA regulation.

Sincerely,

BOB STUMP
Chairman

PERSIAN GULF WAR VETERANS ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON BENEFITS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

OCTOBER 26, 1999

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Compensation for Undiagnosed Illness Under 38 U.S.C. § 1117 and 38 C.F.R. §3.317

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Department of Veterans Affairs Memorandum

Date: August 3, 1998 VAOPGCPREC 8-98

From: Acting General Counsel (022)

Subj: Compensation for Undiagnosed Illness Under 38 U.S.C. § 1117 and 38 C.F.R. § 3.317

To: Under Secretary for Benefits (20)

QUESTIONS PRESENTED:

a. Does 38 C.F.R. § 3.317 preclude compensation for an illness manifested by symptoms that could, in some circumstances, be attributable to a known clinical diagnosis, even if no such diagnosis has been made with respect to the individual seeking compensation?

b. May the Department of Veterans Affairs (VA) pay compensation under 38 U.S.C. § 1117 for disability manifested by symptoms that either elude diagnosis or are attributed to a poorly-defined disease such as chronic fatigue syndrome or fibromyalgia?

DISCUSSION:

1. Section 1117(a) of title 38, United States Code, authorizes VA to pay service-connected disability compensation "to any Persian Gulf veteran suffering from a chronic disability resulting from an undiagnosed illness (or combination of undiagnosed illnesses)" that became manifest during active service in the Southwest Asia theater of operations during the Persian

Gulf War or became manifest to a degree of 10 percent within a presumptive period prescribed by VA. Section 1117(c) of title 38 directs VA to prescribe regulations to carry out that authority which include, among other things, "[a] description of the illnesses for which compensation under [section 1117] may be paid." In February 1995, VA issued 38 C.F.R. § 3.317 to implement the authority of 38 U.S.C. § 1117. Section 3.317(a)(1) provides, in pertinent part:

(a)(1) . . . VA shall pay compensation in accordance with chapter 11 of title 38, United States Code, to a Persian Gulf veteran who exhibits objective indications of chronic disability resulting from an illness or combination of illnesses manifested by one or more signs or symptoms such as those listed in paragraph (b) of this section, provided that such disability:

. . . .

(ii) By history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis.

Section 3.317(b) provides a non-exclusive list of thirteen signs or symptoms which may be manifestations of undiagnosed illness.

2. VA has received a letter from the Chairman of the House Committee on Veterans' Affairs expressing the view that 38 C.F.R. § 3.317 is, in two respects, an unduly restrictive interpretation of the statutory authority conferred by 38 U.S.C. § 1117. The Chairman states, first, that section 3.317(a)(1), read literally, would improperly preclude compensation for an illness manifested by symptoms that could be attributed to a known diagnosis, even if no diagnosis had been made with respect to the particular veteran seeking compensation. Second, the Chairman asserts that section 3.317(a)(1) improperly precludes compensation under 38 U.S.C. § 1117 in all cases where a diagnosis has been made for the illness in question. With regard to the second contention, the Chairman asserts that the regulations should mandate compensation for illness manifested by symptoms which either elude diagnosis or, if a diagnosis is rendered, are attributed to a poorly-defined disease such as chronic fatigue syndrome or fibromyalgia.

3. With regard to the first issue, we understand the question presented to be whether 38 C.F.R. § 3.317 precludes compensation pursuant to section 1117 when the signs or symptoms exhibited by a veteran could, under some circumstance, be attributed to a known clinical diagnosis. For example, 38 C.F.R. § 3.317(b) lists "joint pain" as one of the signs or symptoms which may be manifestations of an undiagnosed illness. VA's schedule of rating disabilities, however, recognizes that joint pain may also be a symptom of arthritis, a "known clinical diagnosis." See 38 C.F.R. § 4.71a, Diagnostic Code 5003. Accordingly, the question is whether section 3.317(a)(1)(ii) would preclude compensation under section 1117 for a Persian Gulf veteran exhibiting joint pain, because joint pain can be attributed to arthritis, regardless of whether the particular veteran's joint pain has actually been attributed to arthritis. We conclude that the regulation does not impose such a restriction. Rather, the language of the regulation indicates that the pertinent inquiry is whether, under the circumstances of the particular veteran's case, the signs or symptoms manifested by the veteran can be attributed to a recognized disease or injury suffered by the veteran.

4. Section 3.317(a)(1) mandates compensation to a Persian Gulf veteran "who exhibits objective indications of chronic disability resulting from an illness or combination of illnesses manifested by one or more signs or symptoms . . . , provided that such disability . . . cannot be attributed to any known clinical diagnosis." (Emphasis added.) The words "such disability," as used in the regulation, refer to the disability exhibited by the veteran seeking compensation, as manifested by the veteran's signs or symptoms. The requirement that the veteran's disability "cannot be attributed to any known clinical diagnosis," on its face, requires a determination as to the nature and cause of that particular veteran's disability, based on the evidence in the particular case. If a claimant suffers disability manifested by a sign or symptom, such as joint pain, which cannot, in that veteran's case, be attributed to a known clinical diagnosis, such as arthritis, the requirement in 38 C.F.R. § 3.317(a)(1)(ii) will be met and compensation may be

paid if the veteran satisfies the other statutory and regulatory criteria. It is, therefore, irrelevant whether the signs or symptoms exhibited by the veteran could be attributed to a known clinical diagnosis under a different, hypothetical set of facts which are not actually present in the veteran's case.

5. Under 38 C.F.R. § 3.317(a)(1)(ii), the determination as to whether a veteran's disability can "be attributed to any known clinical diagnosis" must be based on "history, physical examination, and laboratory tests." The phrase "history, physical examination, and laboratory tests," as used in that regulation, is most naturally read to refer to the particular veteran's history, and to physical examination and laboratory tests conducted with respect to the particular veteran. VA regulations provide that each veteran's disability must be evaluated in relation to its history and to the findings on physical examinations of the veteran. 38 C.F.R. §§ 4.1 and 4.2. VA's schedule of disability ratings indicates that the diagnosis of certain conditions may depend upon complete medical examination of the particular veteran's disability. See, e.g., 38 C.F.R. § 4.42. Accordingly, 38 C.F.R. § 3.317(a)(1)(ii) requires only that the history, physical examinations, and laboratory findings regarding a particular veteran not provide a basis for attributing such veteran's signs or symptoms to any known clinical diagnosis. The fact that particular signs or symptoms could be attributed to a known clinical diagnosis under other circumstances not presented in the particular veteran's case would not preclude compensation under that regulation.

6. The second question presented pertains to whether VA has authority to pay compensation under 38 U.S.C. § 1117 for disability manifested by symptoms which either elude diagnosis or, if diagnosed, are attributed to a poorly-defined disease such as chronic fatigue syndrome or fibromyalgia. As used in the opinion request, the concept of poorly-defined diseases apparently refers to diseases which are recognized by the medical and scientific community as known and diagnosable diseases, but which are defined in terms that may arguably be characterized as vague, general, or controversial and, therefore, may not be diagnosed consistently by different physicians treating similarly-situated patients. The opinion request and the letter from a member of Congress referenced in the opinion request identify chronic fatigue syndrome and fibromyalgia as examples of poorly-defined diseases. VA has adopted provisions in its schedule for rating disabilities setting forth the identifying criteria for those two conditions. Chronic fatigue syndrome is a condition of unknown etiology which often involves multiple body systems. See 59 Fed. Reg. 60,901 (1994). Under VA's rating schedule, diagnosis of chronic fatigue syndrome requires the following three elements: (1) the new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months; (2) the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and (3) the presence of at least six of ten other specified symptoms. 38 C.F.R. § 4.88a. "Fibromyalgia is a syndrome of chronic, widespread musculoskeletal pain associated with multiple tender or 'trigger' points, and often with multiple somatic complaints." 61 Fed. Reg. 20,438, 20,439 (1996). VA's rating schedule indicates that symptoms associated with fibromyalgia may include fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, and Raynaud's-like symptoms. 38 C.F.R. § 4.71a, Diagnostic Code 5025.

7. VA has authority under 38 U.S.C. § 1110 to pay compensation for disability due to a diagnosed disease, such as chronic fatigue syndrome or fibromyalgia, regardless of whether the disease may be characterized as poorly defined. However, in the absence of an applicable presumption of service connection, veterans seeking compensation for such disability must submit evidence that their diagnosed disease was incurred in or aggravated by service. In contrast, 38 U.S.C. § 1117(a) and 38 C.F.R. § 3.317(a) establish a presumption of service connection for Persian Gulf veterans who manifest disability due to an undiagnosed illness to a 10-percent degree prior to December 31, 2001. Accordingly, the issue implicated by the second question is whether the presumption of service connection under 38 U.S.C. § 1117(a) and 38 C.F.R. § 3.317(a) may be applied to diseases which have been diagnosed, but which are attributed to a poorly-defined disease, such as chronic fatigue syndrome or fibromyalgia.

8. On its face, 38 U.S.C. § 1117(a) confers no authority to grant presumptive service connection for any diagnosed disease, regardless of whether the disease may be characterized as poorly defined. Section 1117(a) authorizes VA to pay compensation "to any Persian Gulf veteran suffering from a chronic disability resulting from an undiagnosed illness (or combination of undiagnosed illnesses)" which became manifest in service in the Southwest Asia theater or within a prescribed presumptive period. (Emphasis added.) The term "undiagnosed illness," read literally, means an illness which has not been diagnosed. It is well established that the plain meaning of a statute's language is controlling except in "'rare and exceptional circumstances,' when a contrary legislative intent is clearly expressed." Ardestani v. Immigration and Naturalization Serv., 502 U.S. 129, 135-36 (1991) (citation omitted) (quoting Rubin v. United States, 449 U.S. 424, 430 (1981)).

9. We have found no indication that applying 38 U.S.C. § 1117(a) in accordance with its plain meaning would contravene any clearly expressed legislative intention. The legislative history indicates that the purpose of 38 U.S.C. § 1117(a) is to authorize compensation for disability due to illnesses which cannot be diagnosed. The provisions codified in section 1117 derived from H.R. 4386, 103d Cong., 2d Sess. (1994), provisions of which were incorporated, with certain amendments, into the Veterans' Benefits Improvements Act of 1994, Pub. L. No. 103-446, § 106, 108 Stat. 4645, 4650. The legislative history of H.R. 4386 indicates that the provisions in section 1117 were enacted in response to a determination by VA that it lacked authority under 38 U.S.C. § 1110 to pay compensation for disability in cases where the underlying illness could not be diagnosed and, therefore, the disability could not be attributed to any disease or injury. H.R. Rep. No. 669, 103d Cong., 2d Sess. 6 (1994). In explaining the purpose of this provision, the Committee on Veterans' Affairs of the House of Representatives stated:

> The primary purpose is to provide disability compensation on a presumptive basis to certain veterans of the Persian Gulf War who suffer chronic disabilities resulting from undiagnosed illnesses attributed to their service in the Persian Gulf. The Secretary of Veterans Affairs has indicated that current law does not permit the VA to grant service connection in these cases due to the absence of a diagnosis of the underlying illness. As indicated in a June 10, 1994, memorandum to the Secretary of Veterans Affairs [VAOPGCADV 26-94 (O.G.C. Advis. 26-94)], it is the opinion of the VA's General Counsel that "because the VA is authorized to compensate only for disease-caused or injury-caused disabilities, unless the VA can ascribe a disability to a disease or injury, there is no authority to compensate. The pending legislation supplies that needed additional authority."

H.R. Rep. No. 669, 103d Cong. at 6. The legislative history indicates that 38 U.S.C. § 1117 was intended to remedy the situation in which the absence of a diagnosis precluded an award of compensation under 38 U.S.C. § 1110. That purpose is consistent with the plain language of section 1117(a), which authorizes compensation only for "undiagnosed illness."

10. To the extent that the legislative history discusses service connection for diagnosed illnesses, it merely reflects a congressional understanding that VA had authority under existing law to provide compensation for such illnesses and to prescribe rules for adjudication of claims based on such illnesses. At a June 9, 1994, hearing on H.R. 4386, the bill's chief sponsor stated that, "[v]eterans whose sicknesses are diagnosed are eligible for compensation. The law provides benefits for these veterans. I think we have to provide for Persian Gulf veterans who are suffering from undiagnosed illnesses, who are unable to work." Hearing Before the Subcommittee on Compensation, Pension and Insurance of the Committee on Veterans' Affairs, House of Representatives, 103d Cong., 2d Sess. 9 (June 9, 1994) (statement of Cong. Montgomery). In its report on H.R. 4386, the House Committee on Veterans' Affairs discussed the similarities between chronic fatigue syndrome and the undiagnosed illnesses of Persian Gulf veterans and noted that, "[a]lthough the etiology of [chronic fatigue syndrome] currently is not known, the Secretary of Veterans Affairs testified that [chronic fatigue syndrome] will be added to the VA rating schedule and guidance has been established for adjudication of [chronic fatigue syndrome] claims." H.R. Rep. No. 669, 103d Cong. at 20-21. These statements are

consistent with the conclusion that Congress intended to authorize compensation under 38 U.S.C. § 1117 only for illnesses which could not be diagnosed and did not intend to alter VA's existing authority to pay compensation for diagnosed illnesses. In discussing chronic fatigue syndrome, the House Committee on Veterans' Affairs appears to have acknowledged that compensation for that condition would be governed by existing law and did not indicate any intent that a presumption of service connection be established for that or any other diagnosed condition. Thus, the legislative history of Pub. L. No. 103-446 does not provide the sort of clear evidence of legislative intent which would be necessary to permit VA to depart from the plain meaning of section 1117(a).

11. The Chairman's letter referenced in the opinion request refers to the statement of congressional findings in section 102(2) of Pub. L. No. 103-446, which states:

Significant numbers of veterans of the Persian Gulf War are suffering from illnesses, or are exhibiting symptoms of illness, that cannot now be diagnosed or clearly defined. As a result, many of these conditions or illnesses are not considered to be service connected under current law for purposes of benefits administered by [VA].

Pub. L. No. 103-446, § 102(2), 108 Stat. at 4647 (emphasis added); see also Pub. L. No. 103-446, § 103(1), 108 Stat. at 4648 (referring to "illnesses that cannot now be diagnosed or defined"). The Chairman suggests that the phrase "or clearly defined" reflects a congressional intent to provide compensation for illnesses which have been diagnosed under a disease category which is not clearly defined, such as chronic fatigue syndrome or fibromyalgia. In our opinion, the language of section 102(2) does not clearly convey such an intent. The interpretation advanced by the Chairman is based on the view that the phrase "cannot now be diagnosed or clearly defined" refers to two classes of illnesses, i.e., those which cannot be diagnosed and those which, although they can be diagnosed, cannot be clearly defined. However, that phrase may also be interpreted as referring to a single class of illnesses, i.e., those which can neither be diagnosed nor clearly defined. If the latter meaning was intended, then section 102(2) would clearly be consistent with the language of 38 U.S.C. § 1117(a) authorizing compensation only for disability due to undiagnosed illness.

12. In its report on H.R. 4286, the House Committee on Veterans' Affairs stated that, "[t]he National Institutes of Health Technology Assessment Workshop on the Persian Gulf Experience and Health (NIH Workshop), which met April 27 through April 29, 1994, was unable to develop a working case definition for the so-called 'Persian Gulf Syndrome'." H.R. Rep. No. 669, 103d Cong. at 7. The final statement of the referenced NIH Workshop, included as an appendix to H.R. Rep. No. 669, stated that, "[i]t appears from the information presented that some Persian Gulf veterans have symptoms that are not readily explained by using established disease categories. Under these circumstances, it would be helpful to establish a single case definition to assist in evaluating and managing these veterans." H.R. Rep. No. 669, 103d Cong., 2d Sess. at 51. However, the NIH Workshop panel which prepared the statement concluded that a case definition could not be established due to the lack of data. Id. The NIH Workshop report indicated that the "undiagnosed illnesses" exhibited by Persian Gulf veterans could not at that time be clearly defined by any single set of descriptive criteria. Id. Viewed in relation to this history, the statement in section 102(2) that certain illnesses "cannot now be diagnosed or clearly defined" appears to state only that such illnesses elude both diagnosis and definition and, therefore, does not appear to refer to illnesses which have been diagnosed under arguably ill-defined disease categories. Although this legislative history does not conclusively resolve the meaning of section 102(2) of Pub. L. No. 103-446, it suggests an interpretation of that provision which is entirely consistent with the plain meaning of 38 U.S.C. § 1117(a).

13. Several provisions of Pub. L. No. 103-446 suggest that Congress intended VA would work toward developing diagnoses for the illnesses suffered by Persian Gulf War veterans and improve the process of reaching diagnoses of particular veterans' illnesses. See Pub. L. No. 103-446, §§ 103(2) (stating purpose to develop definitions or diagnoses of illnesses), 104(a) (development of medical evaluation protocol to ensure appropriate diagnosis), 104(a)(4)(A)

(diagnostic tests at non-VA facilities), and 104(e) (directing development of definitions or diagnoses), 108 Stat. at 4649-50. At the same time, Congress authorized payment of compensation to veterans suffering from undiagnosed illness. Pub. L. No. 103-446, § 106, 108 Stat. at 4650; see also Pub. L. No. 103-446, § 103(1), 108 Stat. at 4648 (stating purpose to provide compensation to veterans whose disabilities "cannot now be diagnosed or defined"). These provisions suggest an intention to continue efforts to diagnose illnesses suffered by Persian Gulf veterans and pay compensation to such veterans by existing means, while at the same time providing for payments, under section 1117, to veterans whose illnesses are not yet capable of diagnosis.

14. VA has authority to implement 38 U.S.C. § 1117 by adopting regulations which are necessary or appropriate to carrying out that statute, provided that such regulations are consistent with section 1117. See 38 U.S.C. § 501(a). Further, any such regulations must be supported by a rational basis. See Motor Vehicle Mfrs. Ass'n, Inc. v. State Farm Mutual Auto. Ins. Co., 463 U.S. 29, 43 (1983). Because 38 U.S.C. § 1117(a) authorizes compensation only for disability due to "undiagnosed illness," nothing in that provision would authorize VA to provide presumptive service connection for diagnosed illness. See Manhattan Gen. Equip. Co. v. Commissioner of Internal Revenue, 297 U.S. 129, 134 (1936) ("A regulation which . . . operates to create a rule out of harmony with the statute, is a mere nullity."). However, VA may have authority to adopt reasonable regulations governing the determination as to what constitutes a diagnosis for purposes of section 1117(a). If, for example, there were a rational basis for concluding that some terms employed by physicians do not constitute diagnoses for purposes of section 1117(a) (e.g., because those conditions are not generally recognized in the medical community), then VA would have authority to adopt a regulation providing that the use of such terms would not constitute a diagnosis which would preclude compensation under section 1117(a).

15. In adopting rating-schedule provisions for chronic fatigue syndrome and fibromyalgia, VA appears to have already concluded that those conditions constitute recognized diagnoses. Further, in adopting regulations to implement 38 U.S.C. § 1117, VA rejected the suggestion, submitted during the comment period, that VA adopt a regulatory definition as to what constitutes a "known clinical diagnosis." In rejecting that suggestion, VA stated:

The concept of what constitutes a "known clinical diagnosis" is not such a matter of uncertainty within the medical community as the commenter has implied. Examining physicians routinely determine whether or not an illness is part of a disease process that follows a particular clinical course which can be generally predicted. If the physician is unable to attribute a disability to such a known clinical diagnosis, he or she would routinely include a statement to that effect on the examination report. In the event of conflicting findings, it would be incumbent upon VA to resolve the issue on the basis of all medical evidence of record.

60 Fed. Reg. 6660, 6662 (1995). It appears that VA has opted to rely upon case-by-case determinations, rather than rulemaking, to determine whether a veteran's disability has been attributed to a known clinical diagnosis. We are aware of no basis for questioning VA's determination that chronic fatigue syndrome and fibromyalgia are recognized diagnoses, or its decision not to adopt a regulatory definition of "known clinical diagnosis." Our conclusion that VA has authority to issue a rule defining what constitutes a diagnosis for purposes of 38 U.S.C. § 1117(a) is not intended to imply any view as to whether VA should issue such a rule.

16. Finally, although we conclude that 38 U.S.C. § 1117(a) does not authorize VA to grant presumptive service connection for diagnosed illnesses, we note that VA has authority under 38 U.S.C. §§ 501(a) and 1110 to adopt reasonable presumptions of service connection. See Chemical Mfrs. Ass'n v. Department of Transp., 105 F.3d 702, 705 (D.C. Cir. 1997) ("It is well settled that an administrative agency may establish evidentiary presumptions."). Generally, an agency may establish a presumption only if there is "a sound and rational connection between the proved and inferred facts." Chemical Mfrs. Ass'n, 105 F.3d at 705 (citing, among other authorities, NLRB v. Baptist Hosp., Inc., 442 U.S. 773, 787 (1979)). Pursuant to sections 501

(a) and 1110, VA would be authorized to adopt presumptions of service connection for specific diagnosed conditions manifested by Persian Gulf veterans, if it is determined that a rational basis exists for establishing such presumptions. Again, we express no view as to whether such presumptions are warranted.

HELD:

a. Compensation may be paid under 38 C.F.R. § 3.317 for disability which cannot, based on the facts of the particular veteran's case, be attributed to any known clinical diagnosis. The fact that the signs or symptoms exhibited by the veteran could conceivably be attributed to a known clinical diagnosis under other circumstances not presented in the particular veteran's case does not preclude compensation under section 3.317.

b. Section 1117(a) of title 38, United States Code, authorizes service connection on a presumptive basis only for disability arising in Persian Gulf veterans due to "undiagnosed illness" and may not be construed to authorize presumptive service connection for any diagnosed illness, regardless of whether the diagnosis may be characterized as poorly defined.

John H. Thompson

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SUBCOMMITTEE ON BENEFITS

HEARING ON PERSIAN GULF WAR VETERANS

OPENING STATEMENT OF THE HONORABLE

BOB FILNER, RANKING DEMOCRATIC MEMBER

OCTOBER 26, 1999

Thank you, Mr. Chairman. I am pleased that today's hearing will examine claims filed by Gulf War veterans for compensation of disabilities associated with their Gulf War service. Over 90% of the men and women who served during the Gulf Conflict were under thirty years of age when they went to the Gulf. All were presumably in good or excellent health. Yet, after their Gulf service, many veterans have complained of serious and unexplainable illnesses.

107th Congress, 1st Session ..... H. Doc. 107–3, Vol. II

D

FISCAL YEAR 2002

APPENDIX

BUDGET OF THE
UNITED STATES GOVERNMENT

Trust Funds

GENERAL POST FUND, NATIONAL HOMES

(INCLUDING TRANSFER OF FUNDS)

Unavailable Collections (in millions of dollars)

Identification code 36–8180–0–7–705	2000 actual	2001 est.	2002 est.
01.99 Balance, start of year			
Receipts:			
02.20 General post fund, national homes, deposits	31	29	31
02.40 General post fund, national homes, interest on investments	2	3	3
02.99 Total receipts and collections	33	32	34
Appropriation:			
05.00 General post fund, national homes	−32	−32	−34
07.99 Balance, end of year			

Program and Financing (in millions of dollars)

Identification code 36–8180–0–7–705	2000 actual	2001 est.	2002 est.
Obligations by program activity:			
00.01 Religious, recreational, and entertainment activities	23	24	25
00.02 Research activities	3	3	3
00.03 Therapeutic residence maintenance	1	1	1
10.00 Total new obligations	27	28	29
Budgetary resources available for obligation:			
21.40 Unobligated balance carried forward, start of year	45	50	54
22.00 New budget authority (gross)	32	32	34
23.90 Total budgetary resources available for obligation	77	82	88
23.95 Total new obligations	−27	−28	−29
24.40 Unobligated balance carried forward, end of year	50	54	59
New budget authority (gross), detail:			
Mandatory:			
60.27 Appropriation (trust fund, indefinite)	32	32	34
Change in unpaid obligations:			
Unpaid obligations, start of year:			
72.40 Unpaid obligations, start of year	7	6	6
72.99 Obligated balance, start of year	7	6	6
73.10 Total new obligations	27	28	29
73.20 Total outlays (gross)	−28	−28	−29
Unpaid obligations, end of year:			
74.40 Unpaid obligations, end of year	6	6	6
74.99 Obligated balance, end of year	6	6	6
Outlays (gross), detail:			
86.97 Outlays from new mandatory authority	26	25	24
86.98 Outlays from mandatory balances	2	3	5
87.00 Total outlays (gross)	28	28	29
Net budget authority and outlays:			
89.00 Budget authority	32	32	34
90.00 Outlays	28	28	29
Memorandum (non-add) entries:			
92.01 Total investments, start of year: Federal securities: Par value	51	57	53
92.02 Total investments, end of year: Federal securities: Par value	57	53	55

This fund consists of: gifts, bequests, and proceeds from the sale of property left in the care of the facilities by former beneficiaries; patients' fund balances; and, proceeds from the sale of effects of beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of veterans at hospitals, nursing homes, and domiciliaries where no general appropriation is available. Public Law 102–54 authorizes compensation work therapy and therapeutic transitional housing and loan programs to be funded from the General Post Fund. In addition, donations from pharmaceutical companies, nonprofit corporations, and individuals to support VA medical research are deposited into this fund. (38 U.S.C. chs. 83 and 85.)

Object Classification (in millions of dollars)

Identification code 36–8180–0–7–705	2000 actual	2001 est.	2002 est.
21.0 Travel and transportation of persons	2	2	2
25.2 Other services	10	11	12
26.0 Supplies and materials	11	11	11
31.0 Equipment	3	3	3
32.0 Land and structures	1	1	1
99.9 Total new obligations	27	28	29

VETERANS BENEFITS ADMINISTRATION

Federal Funds

General and special funds:

COMPENSATION AND PENSIONS

For the payment of compensation benefits to or on behalf of veterans and a pilot program for disability examinations as authorized by law (38 U.S.C. 107, chapters 11, 13, 18, 51, 53, 55, and 61); pension benefits to or on behalf of veterans as authorized by law (38 U.S.C. chapters 15, 51, 53, 55, and 61; 92 Stat. 2508); and burial benefits, emergency and other officers' retirement pay, adjusted-service credits and certificates, payment of premiums due on commercial life insurance policies guaranteed under the provisions of Article IV of the Soldiers' and Sailors' Civil Relief Act of 1940, as amended, and for other benefits as authorized by law (38 U.S.C. 107, 1312, 1977, and 2106, chapters 23, 51, 53, 55, and 61; 50 U.S.C. App. 540–548; 43 Stat. 122, 123; 45 Stat. 735; 76 Stat. 1198), [$22,766,276,000, to remain available until expended] *such sums as may be necessary: Provided,* That not to exceed [$17,419,000] *$17,940,000* of the amount appropriated shall be reimbursed to "General operating expenses" and "Medical care" for necessary expenses in implementing those provisions authorized in the Omnibus Budget Reconciliation Act of 1990, and in the Veterans' Benefits Act of 1992 (38 U.S.C. chapters 51, 53, and 55), the funding source for which is specifically provided as the "Compensation and pensions" appropriation: *Provided further,* That such sums as may be earned on an actual qualifying patient basis, shall be reimbursed to "Medical facilities revolving fund" to augment the funding of individual medical facilities for nursing home care provided to pensioners as authorized. *In addition, such sums as may be necessary to provide for any cost-of-living adjustment authorized by 38 U.S.C. 1104. (Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2001, as enacted by section 1(a)(1) of P.L. 106–377.)*

Summary of Budget Authority and Outlays by Program

(In thousands of dollars)

	2000 actual	2001 est.	2002 est.
Distribution of budget authority by program:			
Compensation	18,488,274	20,284,593	21,830,522
Pensions	2,567,771	3,014,634	2,979,714
Burial benefits	112,318	131,049	133,521
Distribution of outlays by program:			
Compensation	19,004,846	18,055,362	21,753,663
Pensions	4,702,725	3,010,994	2,968,214
Burial benefits	112,318	131,049	133,521

Program and Financing (in millions of dollars)

Identification code 36–0102–0–1–701	2000 actual	2001 est.	2002 est.
Obligations by program activity:			
Compensation:			
Veterans:			
00.01 World War II	3,212	3,099	3,131
00.02 Korean conflict	1,288	1,264	1,321
00.03 Vietnam era	6,367	6,695	7,609
00.04 Peacetime service	3,275	3,429	3,792
00.05 Persian Gulf conflict	1,366	1,649	2,065
00.91 Total veterans	15,488	16,138	17,939
Survivors:			
01.01 World War I	34	29	25

Statement by Congressman Tom Udall
3rd Congressional District of New Mexico
Veterans' Affairs Subcommittee on Benefits
H.R. 1929—The Native American Veterans Home Loan Act of 2001
7/10/01

Mr. Chairman:

Thank you for holding this legislative hearing on H.R. 1929, the Native American Veterans Home Loan Act of 2001. It is an honor to testify before the Subcommittee today about this important legislation and I appreciate the opportunity to do so.

Along with 14 of my colleagues, including Ranking Member Lane Evans, I introduced H.R. 1929 on May 21, 2001 to help ensure that the Department of Veterans Affairs' Native American veteran housing loan pilot program is extended. This extension will allow more veterans living on trust lands to take advantage of this important benefit.

The Native American Veterans Loan program currently will expire on December 31, 2001. However, the program has sufficient funds remaining under the original appropriation to provide loans for an additional four years without requiring a new appropriation.

Therefore, the Native American Veterans Home Loan Act of 2001 would extend the direct loan pilot program until December 31, 2005.

Since the inception of the pilot program in 1992, the VA has made 233 direct loans to Native American veterans, which can be used to purchase, construct, or improve a home on Native American trust land. The VA direct loans are generally limited to either the cost of the home or $80,000, depending on which is less. It is worth noting that not one of the homes made possible by this VA direct home loan program has suffered foreclosure.

For a veteran to be able to participate in this program, the veteran's tribe must have entered into a Memorandum of Understanding (MOU) with the VA. In some cases, however, a tribe may have an existing MOU with an agency other than the VA, but is still required to negotiate a separate MOU. My goal is to expedite the process of providing home loans and allow more Native American veterans to take advantage of this pilot program. To do this, my bill waives the need for a second MOU, provided that the existing MOU substantially complies with the VA requirements.

To date, the VA has entered into MOU's with a total of 59 Native American tribes and Native Groups throughout the country, with MOU negotiations continuing with an additional 24 tribes.

Traditionally, Veterans living on tribal land, including allotted land, have not been eligible for VA home loan guarantees. However, the Native American Veteran Direct Loan Pilot Program has allowed many Native American veterans who might otherwise have been unable to obtain suitable housing, to do just that. By extending this Direct Loan Pilot Program for another four years, H.R. 1929 would provide the opportunity for additional deserving Native American Veterans to benefit from this important VA program.

Thank you for the opportunity to testify today, Mr. Chairman. I welcome any questions from the distinguished Members of the Subcommittee.

Testimony of
The Honorable Lois Capps
Before the
Committee on Veterans' Affairs,
Subcommittee on Benefits
July 10, 2001

I am grateful to Chairman Simpson, Ranking Member Reyes, and the Subcommittee for the opportunity to comment on two very important bills before you today: The Veterans Emergency Telephone Service Act and The Gulf War Undiagnosed Illness Act of 2001. As the author of the first bill and an original co-sponsor of the second, I am pleased the Subcommittee is considering these important pro-vet measures.

H.R. 1435, The Veterans Emergency Telephone Service Act, sets up a toll free national veterans' hotline service that can be accessed 24-hours, 7 days a week. This combination "911-411" number for veterans would provide a one-stop, toll free number that veterans can call at any time of day or night for assistance. The bill is based on a similar, very successful program that is operated on a smaller scale by the National Veterans Foundation in Los Angeles.

In the past, toll free information lines for vets have typically dumped them into a frustrating automated system of repeated transfers and long waiting periods. Despite the wide array of services offered by the Department of Veterans Affairs, many veterans assistance programs are unknown to the constituency they intend to support.

Lately, I have heard that the VA has made improvements in the operation of their information lines. If that is the case, and I hope it is, I commend the VA for their progress. However, as recently as last week, one of my staff called the information line operated by the VA and was forced to wait on hold for 31 minutes.

Even if the information lines have improved, their availability and scope is limited by design. A regional information line for veterans on the Central Coast of California is only available from 7:30 am to 3:30 pm, Monday through Friday. And crisis intervention is not a service that is currently provided to veterans over the information line.

Sadly, there is a critical need for veterans and their loved ones to have 24-hour/ 7 day a week access to information and crisis intervention services. Should this bill become law, veterans in need of assistance would be able to call from anywhere in the country, free of charge, to receive immediate help or referral to services close to their homes.

This service would provide immediate and constant access to counseling and crisis intervention services, including suicide prevention, substance abuse rehabilitation

programs, and mental health services. It would provide vital information to destitute veterans in need of emergency food and shelter services. Some calls may be so desperate, immediate crisis intervention is essential to save a life.

This hotline would also provide information on medical treatment, employment training and opportunities, and small business assistance programs.

For routine inquiries that are normally and capably handled by existing toll-free numbers at the VA, the "911-411" operators may simply give general guidance and refer the caller to the appropriate VA resource.

The "911-411" hotline has a bargain basement cost when compared to its far-reaching and much-needed benefits. I have seen a business plan that shows costs of only $2 million per year for a hotline that would be available to veterans at any time of the day or night in all 50 states. This is a small price to pay for the critical, urgent assistance that it provides for our veterans.

By virtue of their service and sacrifice on behalf of this nation, our veterans deserve the very best support services we can provide them, especially in their moments of greatest need. Sadly, such moments don't always occur between the hours of 7:30 am and 3:30 pm, Monday through Friday.

Another important bill before you today is H.R. 1406, the Gulf War Undiagnosed Illness Act of 2001. I want to commend the Committee and ranking member Lane Evans for his leadership on this issue. This legislation would give the VA the authority to protect compensation for undiagnosed illnesses when VA determines that such protection is needed to ensure adequate participation by veterans in VA-sponsored medical research. This guarantee is particularly important for research that requires a high level of participation to achieve valid findings.

Last year, the VA conducted medical research to study the possible association between Gulf War veterans and Amyotrophic Lateral Sclerosis (ALS), commonly known as "Lou Gehrig's Disease". As you may know, this disease holds particular importance to me. I authored the first bill to help ALS victims—a waiver of the 24-month waiting period for Medicare benefits for ALS patients. As it happens, this bill took effect last week and I would like to thank the members of the Subcommittee for their help in its passage.

Since ALS is a relatively rare condition, it was critical that all potentially affected veterans participate in the study. However, there was some concern that veterans receiving compensation on the basis of an "undiagnosed illness" may have been wary of participating for fear of losing their benefits.

VA has taken the position that current law prevents them from acting to protect individuals who participate in such research studies from loss of compensation if a medical condition such as ALS is diagnosed during the research. This places veterans and the VA in a classic "Catch-22" situation. If research demonstrates that Gulf veterans are at increased risk for ALS or another medical condition, a scientific basis could be established for compensation. On the other hand, if veterans who might have ALS or another medical condition decline to participate in the study because of concerns about losing compensation benefits for themselves and their families, the data may not be sufficient to establish an association and advance our understanding of Gulf War Illness.

I am very concerned that this situation could be repeated again and again. This would hurt efforts to understand diseases like ALS as well as vets and their families.

I hope the Subcommittee can move forward on both of these important bills. Thank you again, Mr. Chairman.

THE HONORABLE ELTON GALLEGLY
Statement on H.R. 612
The House Veterans' Affairs Subcommittee on Benefits
July 10, 2001

Mr. Chairman, thank you for holding this hearing today to consider legislation to improve veterans' benefits, including legislation to provide sick Gulf War veterans with the compensation they deserve. I introduced H.R. 612, the Persian Gulf War Illness Compensation Act of 2001, with my colleagues Congressmen Don Manzullo (R-IL) and Ronnie Shows (D-MS). This bill would make it easier for veterans who suffer from Gulf War-related illnesses to receive compensation. With 221 cosponsors, our bipartisan measure is the only Gulf War illness bill to have the support of a majority of the House of Representatives and a number of major veterans organizations.

As one of the original cosponsors of the 1991 resolution to authorize then-President Bush to use force in the Persian Gulf, I believe we must to take care of the men and women who went to war against Iraqi dictator Saddam Hussein and are now suffering from unexplained and devastating ailments. Many of those suffering from Gulf War Illness were Reservists and National Guardsmen uprooted from their families and jobs. They answered the call, and we have a duty to help them.

According to the California Veterans Administration, more than 54,000 men and women from my district served in the Persian Gulf War. Thousands of these veterans came home and developed symptoms for which they still are being denied compensation.

It is likely that Americans who fought in the Persian Gulf War have been exposed to chemical weapons or other harmful chemical or biological agents. The Department of Veteran Affairs, which has the option to compensate and treat veterans for undiagnosed illnesses, has denied 78.5 percent of Gulf War Illness claims presented to it. This is unacceptable.

The VA has too narrowly implemented legislation we passed in the 103rd Congress (Public Law 103-446) to grant sick Gulf War Veterans relief by limiting compensation to only those veterans whose "illness . . .[which] by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis." So if any of the symptoms of a veteran's illness are diagnosable, or if the veteran is misdiagnosed with having another recognizable illness, the veteran does not get compensation. H.R. 612 will close this loophole that has denied these veterans their just compensation.

Under Persian Gulf War Illness Compensation Act of 2001, the Department must recognize that veterans are suffering from the illness if they meet certain criteria. To qualify for benefits, a veteran must have served in the Gulf conflict between Aug. 2, 1990, and Dec. 31, 1991. In addition, the veteran must have suffered from one or more chronic conditions, including fatigue, unexplained rashes, severe headaches, joint pain, muscle pain, sleep disturbances and circulatory disorder. The symptoms must manifest themselves by Dec. 31, 2011.

With the recent passing of the tenth anniversary of the Gulf War, it is time to finally take care of these brave men and women who served their country honorably. I urge you to include H.R. 612 in any comprehensive veterans' benefits bill you are putting together.

STATEMENT OF

JOSEPH THOMPSON

UNDER SECRETARY FOR BENEFITS

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

HOUSE COMMITTEE ON VETERANS' AFFAIRS

JULY 10, 2001

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify today on several legislative items of great interest to veterans. Accompanying me today is Dr. John Feussner, Chief Research and Development Officer.

H.R. 862

The first measure I will discuss, Mr. Chairman, is H.R. 862. This bill would amend section 1116 of title 38, United States Code, by adding diabetes mellitus (Type 2) to the list of diseases presumed to be service connected in veterans exposed to certain herbicide agents. In view of final rules recently issued by VA concerning this subject, we believe this bill is not necessary.

Section 1116(b)(1) of title 38, United States Code, directs VA to establish presumptions of service connection for diseases shown to have a "positive association" with exposure to herbicide agents. On May 8, 2001, VA published in the Federal Register a final rule which adds Type 2 diabetes to the regulatory list, contained in 38 C.F.R. § 3.309(e), of diseases VA presumes to be service connected in veterans exposed to certain herbicide agents in service. This final rule effectuates the purpose of H.R. 862.

Section 1116(a)(1)(B) of title 38, United States Code, expressly establishes a presumption of service connection for each disease that "the Secretary determines in regulations prescribed under this section warrants a presumption of service-connection by reason of having a positive association with exposure to an herbicide agent." Inasmuch as the statute already

incorporates by reference the diseases identified in VA regulations issued pursuant to section 1116, and VA has included diabetes mellitus, Type 2 in those regulations, we believe it is unnecessary to amend section 1116 to specifically mention diabetes mellitus, Type 2.

Congress has not amended section 1116 to include specific reference to each disease for which VA has previously established a presumption of service connection by regulation. For example, in 1996, VA issued a final rule establishing presumptions of service connection for prostate cancer and acute and subacute peripheral neuropathy in veterans exposed to certain herbicide agents. We see no need for legislative action ratifying these regulatory determinations.

Because H.R. 862 would merely reiterate requirements of existing statute and regulation, its enactment would result in no additional costs to VA.

H.R. 1406

The "Gulf War Undiagnosed Illness Act of 2001," H.R. 1406, would amend section 1117 of title 38, United States Code, which governs compensation for certain Gulf War veterans. We cannot support the enactment of section 2 of this bill, but we support the enactment of section 3.

Section 2 of H.R. 1406 would amend section 1117 to include "fibromyalgia, chronic fatigue syndrome, a chronic multisymptom illness, or any other ill-defined illness (or combination of ill-defined illnesses)" among the illnesses for which a presumption of service connection may be established for resulting chronic disability suffered by Gulf War veterans. Currently, section 1117 provides that the Secretary may pay compensation to any Gulf War veteran suffering from a chronic disability resulting from an undiagnosed illness (or combination of undiagnosed illnesses) that became manifest during active service in the Southwest Asia theater of operations during the Gulf War or became manifest to a compensable degree within a presumptive period (currently ending on December 31, 2001) as determined by regulation.

With regard to fibromyalgia and chronic fatigue syndrome, under current law service connection may be established on a direct basis for disability resulting from either of these conditions. Each is recognized as diagnosable under VA's schedule for rating disabilities. Accordingly, we cannot support the inclusion of either condition in section 1117. With regard to other "conditions"

that would be added by section 2, the descriptions of those conditions ("chronic multisymptom illness" and "any other ill-defined illness") are very vague and would result in great uncertainty regarding proper implementation. The Department is pursuing multiple research initiatives intended to identify diseases or conditions that may be associated with service in the Gulf. The results of this research will provide a scientific foundation for decisions on possible presumptive service-connection of diseases or conditions found in veterans of the Persian Gulf War.

Section 3 of the bill would authorize the Secretary, with respect to medical research projects sponsored by VA, to render a determination that medical information derived directly or indirectly from the participation in such a project by a Gulf War veteran who is in receipt of disability compensation under either section 1117 or 1118 of title 38, United States Code, may not be used in adjudicating such veteran's entitlement to such compensation. Such determination would be based on a finding that it is necessary for the conduct of the project that Gulf War veterans participate without fear of loss of compensation. The Secretary would be required to publish in the Federal Register a notice of each determination made under this authority with respect to each medical research project concerned. This authority would be available for the Secretary's use with respect to any VA medical research project whether commenced before, on, or after the date of enactment of the bill.

Veterans who suffer from undiagnosed illnesses should not be discouraged from participation in significant research projects that may result in a better understanding of illnesses associated with Gulf War service or in beneficial treatment of their disabling conditions. In addition, if significant numbers of Gulf War veterans who suffer from undiagnosed illnesses refuse to participate in such research projects out of fear that their entitlement to compensation may be adversely affected, the results of such studies may be rendered unreliable. Accordingly, Mr. Chairman, we support this provision.

H.R. 1406 is subject to the PAYGO requirements of the Omnibus Budget Reconciliation Act of 1990, and, if enacted, it would increase direct spending. We estimate that enactment of H.R. 1406 would result in benefit costs of $15.3 million in Fiscal Year 2002 and a total benefit cost of $87.4 million for the five-year period from FY 2002 through FY 2006. In addition, we estimate that administrative costs associated with enactment of this provision would total $819,000 during that five-year period. Because undiagnosed illnesses of Gulf War veterans are already subject to a presumption of service connection under

38 U.S.C. § 1117 and it is not clear whether any additional illness would be service connected as an "ill-defined illness," the estimates reflected above relate only to the addition of fibromyalgia and chronic fatigue syndrome as new presumptive conditions under that section.

H.R. 1435 & H.R. 1746

H.R. 1435 and H.R. 1746 address the same basic issue, Mr. Chairman, so I will discuss these two measures together. Both bills deal with VA having a centralized toll-free telephone number that enables veterans Nationwide to receive complete and accurate information regarding benefits for veterans from not only VA but also from a variety of Federal and state agencies.

Although we fully support this goal, we are unable to support H.R. 1435 and believe we are already in substantial compliance with the implied mandate of H.R. 1746.

H.R. 1435 would authorize the Secretary to award a grant to a private, nonprofit entity to develop and operate a national, toll-free telephone hotline to provide information and assistance to veterans and their families. This hotline would provide general information about VA benefits, and also provide crisis intervention counseling, information regarding emergency shelter and food, substance-abuse rehabilitation, employment training and opportunities, and small business assistance programs.

H.R. 1746 would require VA to provide a single toll-free phone number to enable the public to have access to veterans benefits counselors. The Secretary must ensure that these counselors have information about veterans benefits provided by all Federal and state agencies.

We would first note, Mr. Chairman, that the Veterans Benefits Administration has had a national toll-free number, 1-800-827-1000, since 1993. This number is listed in the blue pages of telephone books under the heading "benefits information." Veterans call this number every day and receive information not only about VBA benefits, but also benefits administered by the Veterans Health Administration and the National Cemetery Administration as well as benefits offered by other Federal and State agencies.

VBA's telecommunications concept is based on three customer service objectives:

- Accessibility (the call gets through);
- Responsiveness (get call to the right place); and
- Reliability (VA gives the correct answer).

Our goals for our telephone system include:

- Reduce blocked calls to 1 percent;
- Reduce abandoned calls to 2 percent;
- Reduce the volume of calls and misdirected calls; and
- Direct calls to program experts based on business rules.

While VA believes our efforts substantially comply with the intent of H.R. 1746, we recognize that there is more we can do. For this reason, we continue to monitor and modify our telephone service to ensure veterans receive the highest quality service from VA consistent with these goals and objectives. In May, the Secretary directed the Department to explore establishing a cost-effective centralized call center available on a 24/7 basis which would be able to respond to general inquiries about the full range of veterans benefits and health care services. That study is ongoing and will be completed shortly. VBA is also currently implementing initiatives, such as Virtual Information Center and Case Call Routing, that will improve telephone service and utilize our Veterans Service Representatives more efficiently. Case Call Routing will allow callers to call their case management team. Virtual Information Centers (VIC) allows us to adopt a Service Delivery Network (SDN) strategy to handle general calls.

We also developed the State Benefit Reference System in FY 2001. This system provides VA employees computer-based information about veterans benefits offered by State agencies. We are investigating the development of a similar system for VA and non-VA federal benefits for use by VA counselors and veterans self-service on the internet.

VA should have the flexibility to use the latest technologies in a way that will be of the greatest assistance to our veterans and other customers. Certain types of benefit issues may require a separate toll-free number to direct calls to subject-matter experts. In addition, the issue as to whether a private entity, as envisioned by H.R. 1435, rather than VA personnel should operate such a system requires further study.

We would be pleased to meet with your staff and discuss VA telecommunications concerns and initiatives.

H.R. 2359

VA supports the enactment of H.R. 2359, if the bill's PAYGO costs of $15 million over five years can be accommodated within the budget limits agreed to by the President and the Congress.

Section 1 of H.R. 2359 would authorize the payment of unclaimed National Service Life Insurance (NSLI) and United States Government Life Insurance (USGLI) proceeds to an alternate beneficiary. VA supports the enactment of section 1 of this bill.

Under current law, there is no time limitation under which a named beneficiary of an NSLI or USGLI policy is required to file a claim for proceeds. Consequently, when the insured dies and the beneficiary does not file a claim for the proceeds, VA is required to hold the unclaimed funds indefinitely in order to honor any possible future claims by the beneficiary. VA holds the proceeds as a liability. While extensive efforts are made to locate and pay these individuals, there are cases where the beneficiary simply cannot be found. Under current law, we are not permitted to pay the proceeds to a contingent or alternate beneficiary unless we can determine that the principal beneficiary predeceased the policyholder. Consequently, payment of the proceeds to other beneficiaries is withheld.

A majority of the existing liabilities of unclaimed proceeds were established over ten years ago. As time passes, the likelihood of locating and paying the principal beneficiary becomes more remote. In fact, the older the liability becomes, the more unlikely it is that it will ever be paid even though other legitimate heirs of the insured have been located.

This bill would grant the Secretary authority to authorize payment of NSLI and USGLI proceeds to an alternate beneficiary when the proceeds have not been claimed by the named beneficiary within two years following the death of the policyholder or within two years of this bill's enactment, whichever is later. The principal beneficiary would have two years following the death of the insured to file a claim. Afterwards, a contingent beneficiary would then have two years to file a claim. Payment would be made as if the principal beneficiary had predeceased the insured. If there is no contingent beneficiary to receive the proceeds, payment would be made to those equitably entitled, as determined by the Secretary. As occurs under current law, no payment would be made if payment would escheat to a State. Such payment would be a bar to recovery of

the proceeds by any other individual.

Section 1 of H.R. 2359 would apply retroactively as well as prospectively, and is similar to the time-limitation provisions of the Servicemembers' and Veterans' Group Life Insurance programs and the Federal Employees Group Life Insurance program.

Insofar as payment to beneficiaries is made from the insurance trust funds, there are no direct appropriated benefit costs associated with this section. The liabilities are already set aside and would eventually be paid, either as payment to beneficiaries that eventually claim the proceeds, or released from liability reserves and paid as dividends.

There are approximately 4,000 existing policies in which payment has not been made due to the fact that we cannot locate the primary beneficiary, despite extensive efforts. Over the years, the sum of moneys held has aggregated to approximately $23 million. On a yearly basis, about 200 additional policies (with an average face value of $9600, or approximately $1.9 million annually) are placed into this liability because the law prohibits payment to a contingent beneficiary or to the veteran's heirs. It is estimated that approximately two-thirds of the 4,000 policies will eventually be paid as a result of this legislation. Additionally, in anticipation of the fact that about one-third of these policies will not be able to be paid, nearly $7 million has already been released to surplus and available for dividend distribution.

This section is subject to the PAYGO requirements of the Omnibus Budget Reconciliation Act of 1990, and, if enacted, it would increase direct spending. The Administration estimates that its enactment would result in PAYGO costs of $15 million during Fiscal Years 2002-2006 and a total of $25 million during Fiscal Years 2002-2011.

Adjudication of these 4,000 policies would entail administrative costs of approximately $154,000, representing two full-time employee equivalence (FTE) in claims processing and support. Approximately 94 percent of this cost would be reimbursed to the Veterans Benefits Administration's General Operating Expense (GOE) account from the surplus of the trust funds, leaving about $9,000 in government costs (which assumes that about six percent of the policies are Service-Disabled Veterans Insurance, which has no surplus and for which appropriated funds are used to cover administrative costs).

Section 2 of H.R. 2359 would extend, by 4 years, the sunset for the VA's direct loan program for Native American veterans living on trust lands. VA strongly supports this program, and favors enactment of this provision.

The Native American veteran direct loan program, which was enacted in October 1992, has enjoyed limited success. VA has made over 200 loans under this program to Native American veterans. The majority of these loans have been to Native Hawaiians. This program is currently set to expire December 31, 2001. This provision extends the program until December 31, 2005.

VA recently participated in the Executive Branch's One-Stop Mortgage Initiative, which was an effort to develop a more consistent approach to delivering home ownership opportunities to Native Americans. VA is hopeful that this initiative will increase opportunities and remove barriers to participation in the VA loan program for Native American veterans living on trust lands. VA is also aware of efforts by the Federal National Mortgage Association to increase private-sector lender willingness to make loans on tribal lands.

VA believes a four-year extension of the Native American veteran direct loan program would give both the Executive Branch and the Congress an opportunity to see how various initiatives regarding Native American housing loans affect the ability of these veterans to obtain VA financing, and whether further program modifications are indicated.

H.R. 2359 would also make two changes to the current law.

First, the bill would permit VA to make loans to members of a Native American tribe that has entered into a memorandum of understanding (MOU) with another Federal agency if that MOU contemplates loans made by VA and the MOU generally conforms to the requirements of the law governing the VA program. Current law requires a tribe to enter into an MOU with VA before we can make loans to members of that tribe.

The bill would also modify the current requirement that all VA loan and security instruments contain, on the first page of each such document, in letters two-and-a-half times the size of the regular type face used in the document, a statement that the loan is not assumable without the approval of VA. H.R. 2359 would require that this notice appear conspicuously on at least one instrument (such as a VA rider) under guidelines established by VA in regulations.

Those two amendments would implement recommendations by the One-Stop Initiative. These changes would reduce the administrative burden on Indian housing authorities and bring more uniformity in federal loan program processing procedures. Eliminating the requirement for a separate MOU between each tribe and VA should expand the number of Native American veterans eligible for VA financing. The extremely strict loan assumption notice requirement in the current law has prevented VA from approving the use of uniform loan instruments now used in FHA, "Fannie Mae," and "Freddie Mac" transactions.

We recommend that section 2 of H.R. 2359 be further amended to repeal the requirement that VA outstation, on a part-time basis, Loan Guaranty specialists at tribal facilities if requested to do so by a tribe. We have consolidated loan processing and servicing operations from 46 regional offices to nine Regional Loan Centers, and do not have the resources to outstation loan personnel at various tribal locations. VA continues to make periodic outreach visits to all tribes, and provides training to tribal housing authorities. We believe that we can provide all necessary services to Native American veterans seeking VA housing loans without outstationing employees in remote tribal locations.

We estimate that enactment of section 2 of H.R. 2359 would not require any additional appropriation of loan subsidy. Public Law No. 102-389 appropriated $4.5 million "to remain available until expended" to subsidize gross obligations for direct loans to Native American veterans of up to $58.4 million. We estimate that sufficient funds would be available to cover projected Native American veteran loan volume until at least FY 2005. This section is subject to the PAYGO requirements of the Omnibus Budget Reconciliation Act of 1990, but we estimate the annual cost to be less than $500,000 annually over five years.

Section 3 of H.R. 2359 would eliminate the requirement for appellants to furnish the Secretary of Veterans Affairs with a copy of the notice of appeal filed with the United States Court of Appeals for Veterans Claims (CAVC). VA supports the enactment of section 3 of this bill.

Section 7266(a) of title 38, United States Code, provides that a claimant adversely affected by a decision of the Board of Veterans' Appeals (Board) must file a notice of appeal with the CAVC within 120 days after the date on which the Board mailed notice of the decision to the appellant, in order to obtain review of the Board's decision. Subsection (b) of section 7266 requires such a claimant to furnish VA with a copy of the notice of appeal that he or she files with the CAVC.

Failure to comply with the requirement to file a notice of appeal with the CAVC within 120 days of receiving notice of an adverse Board decision ordinarily will result in a dismissal of the appeal for lack of jurisdiction. Unfortunately, in a number of instances, appellants have mailed their notices of appeal to VA, but not to the CAVC, thinking that they have complied with the statute. Some such appeals have been dismissed because the notices of appeal were not received by the CAVC within the required 120 days. We believe that removal of the requirement that an appellant furnish the Secretary with a copy of his or her notice of appeal will clarify to which entity the notice must be provided, thereby resulting in fewer cases in which appellants, through inadvertence, lose their opportunity to appeal. Removal of this notice requirement will not impair VA's ability to respond to those appeals that are properly filed with the CAVC, because the court routinely notifies VA when an appeal has been docketed. This notice is normally provided to VA within a day or two of the receipt by the CAVC of the veteran's notice of appeal.

There would be no costs associated with the enactment of this section.

H.R. 1929

Mr. Chairman, H.R. 1929 would also extend the sunset for the Native American veteran housing loan program and amend the requirements concerning MOUs. Unlike section 2 of H.R. 2359, it does not address the loan assumption notice. Accordingly, Mr. Chairman, we prefer the language of H.R. 2359, with the additional amendment we have recommended.

H.R. 2361

The "Veterans' Compensation Cost-of-Living Adjustment Act of 2001," H.R. 2361, would authorize a cost-of-living adjustment (COLA) for Fiscal Year 2002 in the rates of disability compensation and dependency and indemnity compensation (DIC). Section 2 of this bill would direct the Secretary of Veterans Affairs to increase administratively the rates of compensation for service-disabled veterans and of DIC for the survivors of veterans whose deaths are service related, effective December 1, 2001. As provided in the President's FY 2002 budget request, the rate of increase would be the same as the COLA that will be provided under current law to veterans' pension and Social Security recipients, which is currently estimated to be 2.5 percent.

We estimate that enactment of this section would cost $376 million during FY 2002, $7.1 billion over the period FYs 2002-2006 and $28.5 billion over the period FYs 2002-2011. Although this section is subject to the PAYGO requirement of the Omnibus Budget Reconciliation Act of 1990 (OBRA), the PAYGO effect would be zero because OBRA requires that the full compensation COLA be assumed in the baseline. We believe this proposed COLA is necessary and appropriate in order to protect the benefits of affected veterans and their survivors from the eroding effects of inflation. These worthy beneficiaries deserve no less.

Mr. Chairman, this concludes my statement. I will be pleased to respond to any questions you or the members of the Subcommittee may have.

STATEMENT OF JAMES R. FISCHL, DIRECTOR
VETERANS' AFFAIRS
AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
VETERANS' BENEFITS

JULY 10, 2001

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to provide testimony on the key veterans' legislation being considered by this Subcommittee. The American Legion continues to be deeply concerned about the future of veterans' earned entitlements and greatly appreciates the leadership of this Committee in addressing these important issues.

H.R. 862 - would amend title 38, United States Code, to add diabetes mellitus to the list of disabilities for which presumptive service connection may be granted in the case of veterans who served in the Republic of Vietnam during the Vietnam Era.

In 2000, the Department of Veterans Affairs (VA) requested the Institute of Medicine (IOM) of the National Academy of Science to review the scientific literature to determine whether there was a relationship between dioxin exposure and an increased incidence of Type 2 (adult-onset) diabetes. The IOM found "limited suggestive evidence" of a link between such herbicide exposure and Type 2 diabetes. The Department of Veterans Affairs subsequently promulgated regulations providing for presumptive service connection in claims by veterans who served in the Republic of Vietnam during the Vietnam Era. These regulations became effective yesterday, July 9, 2001.

Mr. Chairman, The American Legion commends VA for its positive response to the needs of thousands of veterans who served in Vietnam and who are now suffering from diabetes. VA had originally estimated about 25,000 claims would be filed in the current fiscal year. However, they have already received 31,000 claims. VA estimates a total of 220,000 diabetes claims will be filed over the next five years. Clearly, this new workload will have a significant, long-term impact on both mandatory and discretionary funding in FY 2002 and beyond for the Veterans Benefits Administration as well as the Veterans Health Administration.

The fact that VA has regulations in place, which allow veterans with this disability to be compensated raises the question – is legislative action really necessary? We believe it is. In our view, the interests of veterans seeking service connection for diabetes based on exposure to Agent Orange will be better served by having the presumption established by statute rather than by regulation. While the current administration is supportive of this regulatory change, there is nothing to prevent a future administration from arbitrarily issuing regulations restricting or eliminating such claims or benefits. By way of contrast, the public nature of the legislative process makes it more difficult for any administration to make arbitrary or drastic changes in the veterans' benefit programs. The American Legion supports H.R. 862.

H.R. 1406 – The Gulf War Undiagnosed Illness Act, would improve presumptive compensation benefits for veterans with ill-defined illnesses resulting from service in the Persian Gulf War.

Shortly after returning home from the 1991 Gulf War, thousands of Gulf War veterans began complaining of unexplained multiple symptom illnesses that eluded

diagnosis or clear definition. At the time, VA was precluded from compensating veterans for disabilities related to service unless the claimed condition had been clearly diagnosed. Aware that thousands of disabled Gulf War veterans were ineligible for disability compensation because Gulf War veterans' illnesses remained ill defined and poorly understood, Congress developed legislation that would permit VA to compensate these veterans. In 1994, hallmark legislation in the form of PL 103-446 was enacted to ensure compensation for ill Gulf War veterans suffering from unexplained conditions commonly referred to as Gulf War veterans' illness. Yet most Gulf War veterans who have filed a claim for undiagnosed illness compensation have been denied service connection for those conditions. PL 103-446 looked good on paper, but a dismal seventy-five percent denial rate is the current reality for sick Gulf War veterans trying to receive VA service connection for Gulf War-related undiagnosed illness.

Although the final product contained ambiguities in the language that permitted VA to write regulations (38 C.F.R. § 3.317) narrowly interpreting section 1117 of Title 38, floor statements and hearing transcripts from the period during which PL 103-446 was crafted make it clear that Congress intended for VA to compensate Gulf War veterans suffering from disabilities that were likely related to their Gulf War service, regardless of how these illnesses would be labeled by a physician. The original intent of Congress and the spirit of the law were also addressed in a June 3, 1998, letter from House Veterans' Affairs Committee Chairman Bob Stump to Department of Veterans Affairs Secretary Togo D. West. VA's response in the form of General Counsel Opinions and Congressional testimony make it quite clear that it will take legislative action to correct the deficiencies and injustice caused by the vagueness of PL 103-446.

Conditions that fall under the umbrella of Gulf War veterans' illnesses share many symptoms and can be labeled several different ways by physicians. Among the common labels are chronic fatigue syndrome (CFS) and fibromyalgia (FM). Although technically diagnosed, such conditions are not well understood by the medical community and are considered poorly defined because their exact causes remain unknown. Moreover, researchers investigating Gulf War veterans' illnesses recognize that the pattern of symptoms reported by Gulf War veterans overlap with recognized but poorly defined illnesses such as FM and CFS (this point was further discussed and supported earlier this year at a government sponsored Gulf War veterans' illness research conference held in Alexandria, Virginia). Despite this, a veteran with such a diagnosis will be denied compensation under the current undiagnosed illness law.

It must also be kept in mind that physicians undergo years of rigorous training in order to diagnose and treat illness. Yet VA compensates veterans who are examined by physicians who are unable to diagnose their illness. As a result, many disabled Gulf War veterans are left in a very precarious situation. If their examining physician diagnoses their illness, they are ineligible for compensation. If the physician does not diagnose their illness, the veteran becomes eligible for compensation. This scenario would be comical if it did not result in the continued suffering of ill Gulf War veterans. Additionally, there is a growing body of evidence found in the medical literature which suggests that the symptoms of CFS and FM so overlap with each other that these illnesses are sometimes indistinguishable to physicians. CFS and FM are often diagnoses that physicians arrive at after they have excluded other diseases. Patients with these illnesses do not test positive on any available medical tests. For example, one does not test positive for fatigue on a blood test. Although a physician may diagnose these illnesses after spending a great deal of time with a patient, the very nature of such conditions often results in different examining physicians of the same patient diagnosing one or the other, or even none, of these illnesses in the same patient.

As you can see Mr. Chairman, there are many uncertainties and unanswered questions that encompass the multiple unexplained physical symptoms experienced by many Gulf War veterans. To date, research into the possible causes and long-term health effects from the multitude of toxic agents and other hazards Gulf War veterans were exposed to during the war, has been mostly inconclusive. Uncertainty and confusion have also plagued effective treatment and definitive diagnosis, hindering a proper treatment regimen and also, often times, adversely impacting the veteran's undiagnosed illness claim, precluding the veteran from rightfully deserved compensation. This is why

it is imperative that the law allowing compensation for such illnesses recognize the uncertainties and limitations in Gulf War research and treatment in order to establish a fair and just means of compensation for ill Gulf War veterans.

Clarifying the definition of "undiagnosed," for VA purposes under the law, to include poorly defined conditions such as CFS, FM and other such conditions is necessary in order to recognize both the original intent of Congress and the complexities involved with Gulf War-related research and treatment. Doing so would serve to correct the deficiencies in the current law and help to ensure that ill Gulf War veterans receive the compensation to which they are entitled.

The American Legion believes H.R. 1406 will help to more clearly define the definition of undiagnosed illness and to improve the claims process for sick Gulf War veterans. Additionally, The American Legion commends Rep. Evans for including language in H.R. 1406 that would prevent medical information derived from participation in a research project from being used in adjudicating a Persian Gulf veterans' entitlement.

Although The American Legion supports H.R. 1406, we ask the members of this Subcommittee to consider language that will extend the presumptive period for undiagnosed illnesses. The current presumptive period for undiagnosed illness claims is set to expire at the end of this year. However, Gulf War-related research to date, as highlighted by a September 2000 Institute of Medicine (IOM) report on the long-term health effects of exposures during the Gulf War, has been inconclusive. Research is ongoing and IOM is scheduled to release several additional reports on long-term health effects in the future. Therefore, due to the inconclusive nature of Gulf War research and the resulting uncertainties, it would be unconscionable to allow the presumptive period to expire at the end the year. The nature of Gulf War veterans' illnesses and limitations and problems with Gulf War research, as cited by IOM, warrant, at the very least, a ten year extension of the presumptive period.

Rep. Donald Manzullo along with Rep. Elton Gallegly and Rep. Ronnie Shows, has introduced H.R. 612, the Persian Gulf War Illness Compensation Act. In addition to clarifying the definition of undiagnosed illnesses considered under Persian Gulf war illness, H.R. 612 will extend the presumptive period through December 31, 2011. The American Legion supports both H.R. 1406 and H.R. 612.

H.R. 1435 – The Veterans' Emergency Telephone Service Act, would authorize the Secretary of Veterans Affairs to award grants of $2 million for FY 2002 and FY 2003 for the establishment of a national toll-free hotline to provide information and assistance to veterans. The grant, provided to a private, nonprofit entity, would require the grantee to provide general and specific information and assistance to veterans and their families on benefits available under title 38, United States Code, and referrals to appropriate individuals with such expertise. This would include information with respect to the provision of emergency shelter and food, substance abuse rehabilitation, employment and training, small business assistance programs, and other information.

H.R. 1746 – would amend title 38, United States Code, to require VA to establish a single "1-800" telephone number in order to provide public access to veterans' benefits counselors and to ensure that such counselors have available to them information on all Federal and state benefit programs.

Currently, title 38, United States Code, section 7723(b) requires that VA shall establish and carry out all possible programs and services, including special telephone facilities, as may be necessary to make the outreach services provided for under this subchapter as widely available as possible. VA has, in fact, established 1-800-827-1000 as a national toll-free phone number, which provides both general information on veterans' benefits as well as access to veterans' benefit counselors for assistance in individual cases. There are also other VA toll-free phone numbers that provide information and assistance on health care benefits, education, life insurance, debt management, a mammography hotline, CHAMPVA, headstones and grave markers, and a Persian Gulf War and Agent Orange hotline.

Many veterans today also have access to the Internet. VA's Home Page allows a veteran or family member to obtain a wealth of information related to VA programs and services and general benefit information. Individual Veterans Integrated Service Networks (VISNs) and VA medical centers also operate home pages via the Internet. Again, general and specific veterans' benefits information and program service information is available on-line. Veterans and their families are also able to contact veterans' service organizations (VSOs) via the Internet. For those individuals who do not have access to the Internet, improving the conventional methods of disseminating information may be less costly and just as effective as creating a new Federal program.

In the view of The American Legion, HR 1435 would essentially duplicate VA's current toll-free outreach services. Rather than try and establish a new, expensive, private information and assistance phone system, The American Legion suggests that the existing VA system be expanded and improved, as a first-step toward assuring that veterans and their families are able to access all necessary benefits information and program referral information. With respect to HR 1746, we believe the current VA toll-free numbers are an effective means of providing veterans needed benefit information and assistance. Granted, this system has its limitations and problems, however, these can be remedied. While the goal of these legislative initiatives is commendable, there is no assurance that either would result in significantly improved services.

H.R. 1929 – would amend section 3761 of title 38, United States Code, to extend the Native American veterans housing loan program, which currently terminates on December 31, 2001. The purpose of such loans is to permit Native American veterans who are located in a variety of geographic areas and in areas experiencing a variety of economic circumstances to purchase, construct, or improve dwellings on trust land.

The American Legion recognizes the sacrifices made by Native American veterans and has no objection to extending or even making permanent the Native American housing loan program. In testimony submitted to the Senate Veterans' Affairs Committee on June 28, 2001, The American Legion expressed support for S. 228, which would make the Native American veterans housing loan program permanent. Every man and women who has worn the uniform in honorable service to this country deserves the rights afforded them through that service.

H.R. 2359 – would amend title 38, United States Code, to authorize the payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veterans housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims.

Section 1 of this legislation provides for the payment of insurance proceeds to an alternate beneficiary, when the first beneficiary of record cannot be identified. If the first beneficiary does not make a claim for the insurance proceeds within two years of the death of the insured, the proceeds may be paid to another beneficiary designated by the insured. If no claim is made by any designated beneficiary within four years of the death of the insured, VA may determine who is equitably entitled to the insurance proceeds and payment will be made to that individual. The American Legion has no objection to this proposal.

Section 2 would extend the Native American veteran housing loan program through 2005. It would also authorize the use of certain Federal memorandums of understanding with respect to direct home loans to Native Americans, and require the inclusion of a notice on the loan or deed documents that such loans are not assumable without the approval of the Department of Veterans Affairs. As stated previously, The American Legion supports the extension of the Native American veteran housing loan program and we support the provisions contained in H.R. 2359, which seek to improve and extend the Native American veterans housing loan program.

Section 3 would amend title 38, United States Code, section 7266, to eliminate the requirement that the veteran provide notification to the Department of Veterans Affairs,

when a notice of appeal is filed with the United States Court of Appeals for Veterans Claims.

Currently, when the Board of Veterans Appeals issues a final decision, it provides instructions to the appellant on how to seek further action on their claim by VA as well as their right of appeal to the United States Court of Appeals for Veterans Claims (the Court) and the procedure for such appeals. Appellants are also advised that a copy of their Notice of Appeal must be mailed to the VA General Counsel. In a number of instances, appellants have mistakenly sent their Notices of Appeal to the VA instead of the Court, which delayed their receipt by the Court and caused them to be denied as not timely filed. While the Board's instructions may appear to be clear and simple to most people, unintended problems do exist.

The requirement that the appellant "shall" provide the VA with a copy of their Notice of Appeal in title 38, United States Code, section 7266(b) is mitigated by the provision in that same section that "a failure to do so shall not constitute a failure of timely compliance with subsection (a) of this section." If the appellant has filed a timely Notice of Appeal, he or she does not necessarily have to provide VA with a copy of their notice, in order to complete the Court's appeal process.

In our view, the proposed elimination of the requirement for an appellant to notify VA of the filing of a Notice of Appeal would make the Court's appeal procedures less confusing and burdensome for appellants. This would not alter the Court's current administrative procedure whereby VA receives formal notification of all Notices of Appeals received by the Court. The American Legion, therefore, is not opposed to this proposal.

H.R. 2361 -- The Veterans' Compensation Cost-of-Living Adjustment Act would increase the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation (DIC) for survivors of certain service-connected disabled veterans. The percentage of increase in these benefits would be the same as the COLA authorized for beneficiaries under Social Security and would be effective December 1, 2001. The President's proposed budget for the Department of Veterans Affairs for FY 2002 included a cost-of-living adjustment of 2.5 percent, based on the projected increase in the consumer price index.

The American Legion supports the proposal to provide an appropriate COLA for veterans receiving disability compensation and individuals in receipt of DIC benefits. We believe it is important that this Committee take the required action to ensure the continued welfare and wellbeing of disabled veterans and their families by enacting periodic adjustments in their benefits, which reflect the increased cost-of-living. The American Legion also believes that annual congressional hearings on such legislation provide an important forum to discuss issues of concern relating to the compensation and DIC programs, which might not otherwise be available.

Mr. Chairman, that completes my testimony. Again, I thank you for allowing The American Legion to provide comments on these important issues. The American Legion looks forward to working with the members of this Committee to improve the lives of all of America's veterans.

STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON BENEFITS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 10, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, I express my appreciation for this opportunity to present the views of our organization on several pieces of legislation before the Subcommittee.

Mr. Chairman, I wish to commend you, Ranking Democratic Member Reyes, and all members of the Subcommittee for your decision to give hearing consideration to the legislation contained on today's agenda. We deeply value and appreciate the advocacy that this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans.

The legislation pending before this Subcommittee covers a range of issues important to veterans and their families. The DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents and survivors. For the past eight decades, the DAV has been devoted to one single purpose: building better lives for our nation's disabled veterans and their families. During the past 80 years, the DAV has never wavered in its commitment to serve our nation's service-connected disabled veterans and their families.

The centerpiece of DAV programs is our veterans' claims assistance service. We employ a corps of 250 National Service Officers (NSOs) that we have thoroughly trained in veterans' benefits law and the medical aspects of disability evaluation. These NSOs, who are themselves service-connected disabled veterans, must successfully complete a combination of 16 weeks intensive classroom instruction in our own National Service Officer academy and an additional 12 months on-the-job training. Our NSOs provide free benefits counseling and claims assistance to hundreds of veterans and family members each day in DAV offices around the country. For the eleven-month period, from July 1, 2000 to May 31, 2001, DAV NSOs filed 127,620 new claims for veterans and their families seeking benefits from the Department of Veterans Affairs (VA).

Among the several organizations that represent veterans before the Board of Veterans' Appeals (BVA), the DAV represents by far the largest number and percentage of the total number of appellants. In fiscal year (FY) 2000, we provided representation in 11,061 of the cases decided by BVA, which was more than 35% of represented appellants and 32.5% of all appellants.

The DAV is also the largest single practitioner before the United States Court of Appeals for Veterans Claims. Our judicial appeals staff filed 168 appeals in 2000. Of the 127 cases for which a disposition was reached in the Court last year, 122 were reversals or remands. The Court affirmed the BVA decisions in only five of our appeals. We therefore had a remarkable 96% success rate at the Court.

In striving to even more effectively meet veterans' needs and ensure they receive the benefits our grateful nation has authorized for them, we have undertaken two new initiatives to enhance and expand benefits counseling and claims representation services to veterans. The first of the two programs involves outreach to members of the Armed Forces at the location and time of their separation from active service. The second involves services to veterans in the communities where they live.

For benefits counseling and assistance in filing initial claims, the DAV has hired and specially trained 23 Transition Service Officers who will provide these services at military separation centers, under the direct supervision of DAV National Service Officers. This corresponds to goals in the strategic plans of both VA and the DAV. By accepting and deciding compensation claims at separation centers where the service medical records and examination facilities are readily available, VA's strategic plan envisions better, more prompt service to veterans in a way that is also more efficient and effective for VA. This enhancement in assistance to those seeking veterans' benefits

will contribute to the DAV's strategic goal of maintaining its preeminent position as a provider of professional service to veterans.

The DAV's new Mobile Service Office program is a part of the same goal. By taking its service offices on the road to rural America and assisting veterans where they live, the DAV will increase accessibility to the benefits our Nation provides for veterans. The DAV has initially put 12 of these specially equipped mobile offices on tour to make stops in communities across the breadth of the country. In an initial 7-day trial run of one of our Mobile Service Office units in January of this year, we interviewed 616 veterans and other potential claimants. We accepted new powers of attorney to represent 336 claimants, and we completed 458 applications for benefits. This program officially started in March 2001. Since then, we have visited 620 cities around the country. This program promises to be very successful. For its first year, we project that we will conduct 40,000 interviews, take 29,500 applications for benefits, and execute 20,000 new powers of attorney.

H.R. 862

This measure would amend title 38, United States Code, to add Diabetes Mellitus (Type 2) to the list of diseases presumed to be service connected for veterans exposed to certain herbicide agents. Diabetes Mellitus (Type 2) would be added as subparagraph (h) under Section 1116(a)(2) of title 38, United States Code.

This bill would codify the decision of the Secretary of Veterans Affairs, under the authority granted by title 38, United States Code, section 1116, to establish presumptive service connection for Type 2 diabetes as a condition related to exposure to certain herbicide agents. The final rule published by the VA in the May 8, 2001 Federal Register, 66 Fed. Reg. 23,166, implemented the Secretary's decisions.

The DAV supports this legislation.

H.R. 1406

This legislation would amend title 38, United States Code, section 1117, to improve presumptive compensation benefits for veterans with ill-defined illnesses resulting from the Persian Gulf War.

This measure would expand the list of disabilities recognized as a disability resulting from service in the Persian Gulf War. It would add fibromyalgia, chronic fatigue syndrome, a chronic multi-symptom illness, or any other ill-defined illness (or combination of ill-defined illnesses), under subsections (a) and (c) of section 1117.

The bill would also add a provision to allow a Gulf War veteran in receipt of compensation under section 1117 or 1118 to participate in a research project sponsored by VA without fear of losing his or her entitlement to compensation based on medical information derived directly or indirectly from participation in the research project.

The DAV supports the provisions of this legislation to expand the list of disabilities for which service connection can be presumed for Gulf War veterans and to protect the benefits of those Gulf War veterans who participated in VA-sponsored research projects. We note, however, that the presumptive period for the manifestation of undiagnosed illnesses is due to expire at the end of this year. See 38 C.F.R., section 3.317(2000). Section 1117(b) provides that the Secretary shall prescribe the appropriate time period for the presumption. It is extremely important, especially for those men and women who continue to serve in the Persian Gulf region, that the presumptive period not be allowed to expire on December 31, 2001.

If VA is unwilling to extend the date beyond December 31, 2001, then this Subcommittee should propose to amend section 1117(b). We note that H.R. 612 has a provision to extend the presumptive period for an additional 10 years. The DAV supports extending the presumptive period for Gulf War illnesses beyond December 2001.

H.R. 1435

This measure would authorize the Secretary of Veterans Affairs to award grants to provide for a national toll-free hotline to provide information and assistance to veterans and their families, including crisis intervention counseling, general information with respect to veterans' benefits under title 38, United States Code, and information with respect to provisions of emergency shelter and

food, substance abuse rehabilitation, employment training and opportunities, and small business assistance programs. The provisions of this bill limit a grant to a period of not more than two years, with payment subject to annual approval by the Secretary and subject to the availability of appropriations.

The proposed legislation would require a private, non-profit entity to contract with a carrier for use of a toll-free telephone line; employ trained and supervised personnel to answer incoming calls and provide counseling and referral service to callers on a 24-hour-a-day basis; assemble and maintain a current database of information; and publicize the hotline. The private, non-profit organization must demonstrate that it is a nationally recognized expert in the area of furnishing assistance to veterans and have a record of high quality service in furnishing such assistance, including the support from advocacy groups, such as veterans service organizations.

As written, the DAV is opposed to H.R. 1435. This measure attempts to take away an intrinsical part of VA's mission of service to veterans and their families.

Since about 1993, the VA has had a toll-free number whereby veterans or other VA claimants could obtain information about benefits and health care services. VA counselors also have available to them information on benefits offered by other federal departments and agencies and states.

In March 2001, the DAV conducted a nationwide survey of VA's national toll-free hotline. The supervisory NSOs in all of our offices were asked to call the VA toll-free number and track how many times they had to call before they got through and how long they had to wait to receive the requested service. They were instructed to request the "new" Agent Orange Help Line toll-free number, which had been published by the VA the week prior to our survey.

The results of our survey were surprising and somewhat unexpected. In all but a few cases, our NSOs were able to access the help line on the first call. In one case, in Hartford, Connecticut, it took 14 tries before they were able to get through; however, very few NSOs received a busy signal when they called. For the most part, services were rendered in less than five minutes—this was total call time. In the vast majority of the calls, our NSOs received the correct toll-free Agent Orange Help Line phone number. In some cases, our NSOs were put on hold while the counselor obtained the phone number. In a few cases, our employees were referred to either the medical center or the Agent Orange registry. Overwhelmingly, we were informed that the counselors were polite and courteous. In some cases, the counselors offered to provide any additional assistance that might be needed on other matters.

The only complaint we received from a few of our supervisory NSOs dealt with the automated, recorded message they had to listen to before reaching a counselor. It was their concern that older veterans might find it frustrating or difficult to maneuver through. However, it is difficult to imagine how a more effective system might be devised to avoid this situation and still provide a complete menu of available services.

In conclusion, it would appear that our "non-scientific" survey confirms that the current VA toll-free number is working. As with any service, it must be continually monitored, evaluated, and improved.

If this Subcommittee believes that VA is not adequately meeting the needs of veterans or other VA claimants in providing needed information, then VA should be held accountable. If this Subcommittee also believes that 24-hour-a-day access to this information is necessary, then VA should be provided the resources to staff these toll-free telephone lines 24-hours a day.

The DAV does not believe that a private, non-profit organization would be better able to handle this function. Accordingly, we do not support this legislation.

H.R. 1746

This proposed legislation would require the Secretary of Veterans Affairs to establish a single, toll-free telephone number to allow for access by the public to veterans' benefits counselors at the VA. This would be accomplished by amending section 7723 of title 38, United States Code, by adding a new subsection, (c).

It is unclear what the purpose or intent is of this legislation. The VA currently has several toll-free numbers that provide access to the public to inquire about specific information, such as

benefits, health care eligibility and enrollment, life insurance, burial benefits, a sexual trauma help line, and a Gulf War help line.

As discussed above, it appears, based on our survey, that the VA is doing a good job of providing information via their national toll-free hotline.

If the intent of this legislation is to codify the requirement that VA perform tasks and functions similar to those outlined in H.R. 1435, then this bill, H.R. 1746, should specifically set forth those requirements.

H.R. 1929

This bill would amend title 38, United States Code, section 3761 (c), to extend the Native American Veterans Housing Loan Pilot Program.

The program under which VA provides direct housing loans to Native American veterans living on trust lands began as a five-year pilot in 1992. In 1997, the sunset date of September 30, 1997, was extended to December 31, 2001. This proposed legislation would extend the sunset date to 2005.

Although DAV does not have a resolution on this issue, we believe Native American veterans should have the same opportunities for home ownership that other veterans enjoy. Accordingly, the Committee should favorably consider this legislation.

A similar bill in the Senate, S. 228, would make housing loans to Native American veterans a permanent program.

Section 3 of this measure would amend section 3762 (a)(1) of title 38 to authorize the use of certain federal memorandums of understanding. The DAV has no position on this change.

H.R. 2359

This proposed legislation would authorize the payment of National Service Life Insurance (NSLI) and United States Government Life Insurance (USGLI) proceeds to an alternate beneficiary when the primary beneficiary cannot be identified. It would make changes to and extend the Native American Veteran Housing Loan Pilot Program. Finally, it would eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims (CAVC).

Section 1(a) of this bill would amend section 1917 of title 38, United States Code, to allow for the payment of NSLI proceeds to be made to a secondary beneficiary designated by the insured, if the primary beneficiary has not made a claim for such payment within two years after the death of the insured. At that time, the primary beneficiary would be treated as if he or she had predeceased the insured.

Further, if within four years after the death of the insured, no claim has been filed by a designated beneficiary, payment of the insurance proceeds may be made to such person as may, in the judgment of the Secretary, be equitably entitled to such proceeds.

Similar provisions would be added to amend section 1951 pertaining to payment of proceeds under USGLI.

Annually, VA sends out statements to policyholders of their life insurance programs regarding the status of the veteran's insurance policy. Recently, VA requested policyholders to resubmit beneficiary designations so that the form could be electronically filed in VA's new imaging system. This form also requested beneficiaries' social security numbers. As part of their annual mailing to life insurance policyholders, VA should continue to request updated beneficiary information, including social security numbers, from policyholders, to ensure that VA's records are current. In this way, VA can further ensure that it is able to carry out the deceased veteran's wishes as to who is to receive the proceeds of his or her life insurance policy.

It is unclear what VA currently does to ensure that a veteran's beneficiary is located and receives notice that life insurance proceeds are available. Further, a two-year window of opportunity for a primary beneficiary to file a claim appears to be a very short period of time, especially in light

of the fact that after that two-year period, the primary beneficiary is treated as if he or she had predeceased the insured and, therefore, is precluded from receiving the life insurance proceeds. Likewise, a secondary beneficiary would have only two years in which to file a claim after the primary beneficiary's two-year period elapses.

We are unaware of any private insurance company that has similar restrictions. Accordingly, the DAV is opposed to the provisions contained in Section 1 of this measure.

Section 2 (a) of this bill would extend the Native American Veterans Housing Loan Pilot Program to 2005, similar to the provisions in H.R. 1929. As noted, the DAV has no objection to extending this program.

Section 2 (b) and subsection (c) would make additional modifications to section 3762 (a)(1) and 3714 (d) respectively. The DAV has no position on these changes.

Section 3 of this legislation would eliminate the requirement that an appellant, seeking to obtain review by United States Court of Appeals for Veterans Claims, provide a copy of said notice of appeal to the Secretary of Veterans Affairs.

The DAV is not opposed to favorable consideration by the Subcommittee of this provision.

H.R. 2361

This measure would increase the rate of disability compensation, dependency and indemnity compensation, additional compensation for dependents, and the clothing allowance by the percentage of annual increase in the cost of living, with rounding down of the adjusted rates to the next lowest whole-dollar amount. These increases would be effective December 1, 2001.

Mr. Chairman, the DAV supports favorable consideration of this measure. However, we continue to oppose rounding down of compensation increases, and we urge this Subcommittee and the full Committee to reject recommendations to extend the sunset provisions of this deficit reduction provision or to permanently extend rounding down provisions.

Before I close, I would like to commend the members of the full Committee for their swift action earlier this year in passing H.R. 801. As originally passed by the House, H.R. 801 provided for increases in the amount of assistance for automobile and adaptive equipment and specially adapted housing. Unfortunately, the Senate removed these provisions from the bill, which was later signed into law, as Public Law 107-14, enacted on June 5, 2001.

I would encourage this Subcommittee to continue to pursue passage of these important provisions. These provisions are of great benefit to our more seriously disabled veterans. Congress has not protected these important benefits from the severe effects of inflation and increased costs over the years. The value of these benefits has substantially eroded through the years.

This concludes my statement, Mr. Chairman. I would be pleased to respond to any questions you may have.

STATEMENT OF

SIDNEY DANIELS, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE

VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VARIOUS BENEFITS LEGISLATION UNDER CONSIDERATION

WASHINGTON, D.C. JULY 10, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I appreciate the opportunity to comment on the various benefits bills under consideration today.

I would like to take a moment, Mr. Chairman, to congratulate you on becoming Chairman of this subcommittee. We look forward to your stewardship and stand ready to assist you in any way that we can.

The legislation under consideration today is varied. It covers a wide variety of topics that are a concern to our members and to all of our nation's veterans. In general, the VFW supports the legislation being offered, with some exceptions that will be noted below.

H.R. 862--To amend title 38, United States Code, to add Diabetes Mellitus (Type 2) to the list of diseases presumed to be service-connected for veterans exposed to certain herbicide agents.

Mr. Chairman, the VFW strongly supports this legislation that would add a presumption of service connection for veterans who have contracted Diabetes Mellitus (Type 2 Diabetes), as a result of exposure to certain herbicides. This legislation would provide the critically needed benefits for veterans and their dependents who have had to suffer the consequences of this devastating disease.

As part of PL 102-4, *The Agent Orange Act of 1991*, The Institute of Medicine has been charged with determining the effects of Agent Orange, and other herbicides, on those veterans who were exposed during service. Their November 2000 report, *Veterans and Agent Orange: Herbicide/Dioxin Exposure and Type 2 Diabetes*, found that "there is

limited/suggestive evidence of an association between exposure to the herbicides used in Vietnam or the containment dioxin and Type 2 diabetes."

The science clearly indicates that a connection between herbicide exposure and Type 2 diabetes is likely. Because of this, it is important that this legislation be enacted quickly so that our Vietnam veterans can receive treatment for this disease.

H.R. 1406--Gulf War Undiagnosed Illness Act of 2001

The VFW supports this legislation to further clarify the standards used for compensation of Persian Gulf Undiagnosed Illness and to extend protection to veterans by allowing them to continue to receive compensation while they are participating in medical research projects without the fear of losing compensation.

With your permission, I would like to summarize the basis for our support.

In 1998, former Chairman of the House Veterans Affairs Committee, Congressman Bob Stump wrote a letter to the Secretary of Veterans Affairs articulating the committee's concerns surrounding the way in which the VA was narrowly interpreting and implementing PL 103-446, *The Persian Gulf War Veterans' Act*, that was enacted to "provide compensation to Persian Gulf War veterans who suffer disabilities resulting from illnesses that cannot now be diagnosed or defined, and for which other causes cannot be identified...."

In his letter, then Chairman Stump expressed his trepidation and displeasure in that, "[f]or the Department of Veterans Affairs to adjudicate claims on the basis of a rigid distinction between diagnosed and undiagnosed conditions is to ignore altogether what we have come to learn about chronic fatigue syndrome, fibromyalgia, and related ill-defined conditions. Continued reliance on the current regulation (Title 38 CFR section 3.317) ignores that medicine does not fully understand these conditions and that physicians may or may not diagnose them. As is apparent from the literature, they present with many of the same symptoms which have been described in Persian Gulf veterans from the earliest reports and which were the subject of Congress's effort to service-connect veterans who suffer from symptoms of illness which cannot be clearly defined. Thus, for the regulation to effectively rule-out service connection under that law in any case in which a VA physician happens to assign a diagnostic label associated with an ill-defined illness, is to frustrate the purposes of this law, and to raise a serious question of deprivation of due process."

The Undersecretary for Benefits' written response differed markedly from the Committee's interpretation. The VA General Counsel upheld that section "1117 (a) of 38, USC, authorizes service connection on a presumptive basis only for disability arising in Gulf War veterans due to undiagnosed illness and may not be construed to authorize presumptive service connection for any diagnosed illness, regardless of whether the diagnosis may be characterized as poorly defined."

Further, this subcommittee held a hearing October 26, 1999, addressing Persian Gulf War Veterans' Issues in which this specific topic of disability compensation for undiagnosed illness was brought up. When challenged by members of this subcommittee, the Undersecretary for Benefits reinforced the VA's previous position that "the way the law is written, the way your compensation program is structured, we are granting about as many [claims] as we can."

This debate between Congress and the VA over the intent of the law has been going on too long and at the great expense of ill Persian Gulf War veterans. Therefore, in order for Congress to fulfill what it considers, and the VFW concurs, to be the original intent of PL 103-446, legislation such as H.R. 1406 is warranted. Ten years after the Persian Gulf War, the literature supports that certain chronic symptoms are more prevalent among Persian Gulf War veterans. We agree with one VA Health official in that the analysis of "these clusters of symptoms may provide the kind of information that the committee would like to see inform the compensation process." We appreciate the efforts of this Congress and this subcommittee to act on legislation that would ensure that Persian Gulf veterans are not denied compensation for undiagnosed illness under PL 103-446 because of an overly narrow interpretation in how their claims are adjudicated.

As for the measure being proposed that would allow Persian Gulf veterans to participate in a medical research study without loss of benefits if their service-connection for undiagnosed illness is suddenly found to be a condition that has a known diagnosis, it enjoys our full support.

For example, there are veterans who are service-connected for "motor neuron disorder, etiology unknown" that could now very well "mask as Amytropic Lateral Sclerosis (ALS) or "Lou Gehrig's Disease." Certainly, those individuals should have no impediments, either perceived or actual, that would inhibit their participation in an important research program, such as the one being conducted by the Durham VAMC. This legislation would remove the fear of losing their benefits.

We are using this scenario for another very important reason. During October 26, 1999 Congressional testimony before the Subcommittee on Benefits, we raised the specter of a disproportionate number of Gulf War veterans contracting ALS. In a dialogue with then-Chairman Quinn, we mentioned that ALS is "one disability that right now seems to ... qualify for presumption of service connection" as a result of service in the Persian Gulf War area of operations. We based that supposition on the fact that, at that time, "the VA has identified 28 Gulf War veterans with ALS where the expected incident rate should be 27." We also further speculated "the 28 is most likely an under-reported number, mainly because there are a lot of veterans ... [with a present undiagnosed illness of] 'motor neuron disorder, etiology unknown'."

We now understand that the number of Gulf War veterans participating in the Durham study is around 80. This only leads further credence to our suggestion, during that October 26, 1999 Congressional testimony that there should immediately be established a presumption of service connection for ALS as a result of Persian Gulf in-theater service. Further, we strongly recommend, Mr. Chairman, that additional legislation be swiftly introduced and enacted that will accordingly do so.

H.R. 1435--Veterans' Emergency Telephone Service Act of 2001

This legislation would authorize the Secretary of VA to award grants to companies for the purposes of providing a national toll-free hotline to provide information and assistance to veterans. We support this measure without further comment.

H.R. 1746--To amend title 38, United States Code, to require that the Secretary of Veterans Affairs establish a single '1-800' telephone number for access by the public to veterans benefits counselors of the Department of Veterans Affairs and to ensure

that such counselors have available to them information about veterans benefits provided by all Federal departments and agencies and by State governments.

We applaud the intent of this measure to establish a 1-800 line as a means to expand public access to veterans' benefits counselors at the VA. We cannot, however, support this legislation in its current format.

Among other issues, this legislation may have the unintended consequence of misdirecting scarce resources. As presently constructed, this legislation could necessitate the shifting of personnel and resources from other vital areas.

H.R. 1929--Native American Veterans Home Loan Act of 2001

We support this legislation to extend the Native American veteran housing loan pilot program. Currently, this program is set to expire at the end of 2001. This legislation would extend the program an additional four years until 2005.

In a 1998 report entitled *Native American Housing: Homeownership Opportunities on Trust Lands Are Limited*, the GAO determined that private institutions have rarely supplied home purchasing loans. GAO concluded, "Federal government assistance is nearly always required to provide home ownership opportunities to Native Americans on trust lands."

Although the report was written in 1998, the situation has not improved for Native Americans. It is clear that this program should be extended. We would also recommend, that this program not only be extended until 2005, but it should be continued permanently.

H.R. 2359--To amend title 38, United States Code, to authorize the payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veteran housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims.

The VFW supports payment of insurance proceeds to an alternate beneficiary when the first beneficiary cannot be located. However, we recommend that the time limit to pay the first beneficiary designated by the insured be extended to four years, and if within that time period, no claim has been filed, the Secretary may, within five years, designate a person equitably entitled to the proceeds.

We also support the extensions of the Native American veteran housing loan pilot program, for the reasons above.

We further agree with the proposal to eliminate the requirement for providing a copy of notice of appeal to the Secretary.

H.R. 2361--Veterans' Compensation Cost-of-Living Adjustment Act of 2001

The Veterans of Foreign Wars supports the provisions of the Veterans Compensation Cost-of-Living Adjustment Act of 2001. This bill increase the rates of compensation for veterans with service-connected disabilities, and the rates of

dependency and indemnity compensation paid to the survivors of certain disabled veterans.

Although we support this legislation, we oppose the provisions of Sec 2 (c)(3). This section requires that any amount that results in something other than a whole dollar, be reduced to the lowest whole dollar amount.

It is our understanding that the practice of rounding down to the nearest whole dollar was introduced following the passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA). While we certainly understand the importance of the OBRA law in terms of assisting government managers work towards a balanced budget, it is the view of the VFW that our veterans have done more than their fair share to help balance the budget and this need not continue in this day of budget surpluses. We, therefore, oppose the permanent extensions of the OBRA provision that permits rounding down compensation payments.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions that you, or the members of the subcommittee, may have.

Statement of the Honorable Richard H. Baker, Member of Congress
Sixth Congressional District, State of Louisiana

U.S. House of Representatives
Veterans' Affairs Committee
Subcommittee on Benefits

July 9, 2001

Chairman Simpson, Ranking Member Reyes, and members of the Subcommittee:

I commend you for holding this hearing and focusing on means by which constituent services may be improved at the Veterans Affairs Administration. I have recently introduced H.R.1746 which I believe is a good step in the right direction. Please know that I am always open to suggestions on how this measure can be improved. I also want to acknowledge and thank the committee staff for their diligent work and assistance in crafting this legislation.

I believe there is a definite need for a centralized location where veterans can receive accurate, up-to-date and comprehensive information. The one thing I have learned in my years of constituent service in Congress is that a nice and considerate "NO" is much better than a long delay and being ignored. We are not in the position to promise everybody everything, or to attempt to solve every problem by spending every nickel in the world, but we are all in the constituent service business, and a prompt answer to inquiries is expected. The technology to accomplish this is available and I believe it is an investment that the VA must make for our veterans.

Over the course of my service in Congress, many of my veterans have told me that while they know they are entitled to certain benefits, they are not really sure what the benefits are. I'm sure that each one of us here has had similar conversations with veterans. In all fairness, I think it proper to state that the VA has endeavored, through their outreach programs, to disseminate information about available benefits to veterans through a variety of means.

However, Congress has an obligation to ask the question, "Have these efforts been successful?" I think the answer to this question lies in the results of the 1999 Survey of Veterans' Satisfaction with the VA Compensation and Pension Claim Process. This survey reported, among other items, the following:

- 55.9% of veterans rate their own knowledge of VA benefits as excellent, very good, or good;
- 37.8% of veterans believe the VA keeps them apprised of the full range of available benefits and services; and,
- 26.8% of veterans verified that the VA told them about other benefits for which they might be eligible.

We must ask ourselves whether or not this is satisfactory. Should we be satisfied that almost 56 percent of our veterans have a good knowledge of their benefits? Should we be satisfied that only 38 percent of veterans feel they are kept informed of their benefits? Finally, do we believe the VA has an obligation to ensure that veterans are well informed of their benefits across-the-board, regardless of the initial inquiry or the administering agency? My feeling is, and I believe the subcommittee will agree with me, that more needs to be done As I said before, we are all in the constituent services business here in Congress, and each of us knows first-hand the importance of getting that part of our jobs right.

From this survey, it appears that veterans must know a specific question to ask in order to feel satisfied with VA outreach programs. That veterans do not have a great deal of knowledge of benefits for which they are eligible from the VA is troubling. Even more problematic is that many veterans are unaware of the services available to them that are not administered by the VA. While the VA administers roughly 80-90% of veterans benefits, there are other federal agencies that also offer veterans benefits. This includes agencies such as the Small Business Administration, the Department of Housing and Urban Development and the Department of Labor.

In the current economy, access to information is deemed to be one of the most important (if not the most important) tools by which an individual may reach a decision. In my judgement, there is no exception to this rule for our veterans. As a remedy, I have proposed creating one central avenue through which veterans can access information on all available services and benefits to which they may be entitled. Currently, there is no single facility which accomplishes this purpose.

To maximize the benefit to veterans, the contact center should be a responsive, efficient, and dependable medium for information exchange with the agency, whether the contact is made via telephone, email, fax, or through the agency's web site. Those applications that can be automated should be automated. When personal assistance is needed, a veteran should be promptly connected to a Benefits Counselor who is best-matched to meet that veteran's needs. Ideally, a veteran should not have to be "re-introduced" every time they call. The counselor should have information about the veteran readily available regarding the veteran's prior contact with the agency as well as the current benefits the veteran may already be receiving.

Although this center would be administered by the VA, it would serve as a conduit to other federal agencies where veterans could request and receive information. One possible way to organize this is to provide additional training to those employees who staff the current VA Help Line.

Other topics in the system could include:

- Listings of the offices of state and county departments of veterans affairs;
- Community resources (telephone hotlines and homeless shelters);
- Military resources (TRICARE offices, military hospitals, and ID card issuers); and,
- VA facilities (VA medical centers, Vet Centers, VBA regional and satellite offices, and cemeteries).

Every aspect of the system's design should be shaped by experienced employees who have a rich understanding of users' needs. There are a wealth of qualified and compassionate employees who have spent years in the VA and VBA who know (a) how potential users think, (b) what questions veterans frequently ask, and (c) where misunderstandings most often occur. Their expertise will make an invaluable contribution to the success of this contact center.

I believe we can honor our veterans by helping improve the information they receive. Some may say that this is a small project, but I believe that it is the small things that count the most. Our veterans will appreciate the commitment to provide them with prompt, comprehensive and improved services.

Finally, I submit for the record a letter I recently received from my constituent, Mr. James Tindle, on June 21, 2001. Mr. Tindle's letter describes the difficulties he experienced in an encounter with the VA Debt Management Center. After reading his letter, I became even more committed to this endeavor.

RICHARD HUGH BAKER
6TH DISTRICT, LOUISIANA

COMMITTEE ON
FINANCIAL SERVICES

CHAIRMAN
SUBCOMMITTEE ON
CAPITAL MARKETS, INSURANCE AND
GOVERNMENT SPONSORED ENTERPRISES

SUBCOMMITTEE ON
FINANCIAL INSTITUTIONS
AND CONSUMER CREDIT

SUBCOMMITTEE ON
INTERNATIONAL MONETARY POLICY
AND TRADE

Congress of the United States
House of Representatives
Washington, D.C. 20515–1806

COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE

SUBCOMMITTEE ON HIGHWAYS
AND TRANSIT

SUBCOMMITTEE ON AVIATION

SUBCOMMITTEE ON
WATER RESOURCES AND ENVIRONMENT

COMMITTEE ON
VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

June 11, 2001

Mr. James B. Tindle
[redacted]

Dear Mr. Tindle:

Please find enclosed the correspondence which I received from the Department of Veterans Affairs advising me that the Board of Veterans' Appeals denied your appeal of a waiver of recovery of the debt in your account on March 16, 2001. I understand that you were provided with a copy of their decision and a copy of your appeal rights and the four options available to you.

It is suggested that you contact the VA Debt Management Center in St. Paul at 1-800-827-0648, should you have any questions or need additional information about the debt or about the classification of debt reporting.

Please notify my office regarding your decision to appeal or if you decide to take one of the four options that are available. I want to help you in any way I possibly can and look forward to hearing from you.

Sincerely,

Richard H. Baker
Member of Congress

RHB\ml
Enclosure

341 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515-1806
(202) 225-3901
(202) 225-7313 (FAX)

5555 HILTON AVENUE
SUITE 100
BATON ROUGE, LA 70808
(225) 929-7711

Lisa
800# Complaint

6-21-01

Ms. Mary Lang,
Congressman Baker:
Reference our conversation on 6-20-01

On that same date I called the 800-827-0648 Appeals (BVA). I was informed by a female (She would not give me her name) that the debt had been written off. I then ask for a letter and she informed me that I would not get a letter. At this time she was getting very "huffy".

I ask her about the fact that it had been reported as a bad dept to the credit bureau. She gruffly said it would stay there until 2002. When I told her that I was informed along time back that it would not be reported as long as it was before the Appeals Board. She said you cannot have your cake & eat it too! She further stated they could take it off from "written" off and demand that I start making payments if I was not satisfied

I became very upset and told her Good Bye.
Sincerely Yours

DEPARTMENT OF VETERANS AFFAIRS
Regional Office
701 Loyola Avenue
New Orleans, LA 70113

RECEIVED
JUN 05 2001
Congressman Richard H. Baker

JUN - 4 2001

In Reply Refer To: 321/21

The Honorable Richard H. Baker
Member, House of Representatives
5555 Hilton Blvd., Suite 100
Baton Rouge, LA 70808

[redacted]
TINDLE, James B.

Your Reference:
Letter dated May 17, 2001

Dear Mr. Baker:

We have your letter of May 17, 2001, about Mr. James B. Tindle.

BVA Decision

The Board of Veterans' Appeals (BVA) denied Mr. Tindle's appeal of waiver of recovery of the debt in his account on March 16, 2001. He should have received a copy of that decision, which would also have included a copy of his appeal rights and the four options still available to him.

More Information

Should Mr. Tindle wish information about the classification of debt reporting or any information about the debt which was created, he should contact our VA Debt Management Center in St. Paul at 1-800-827-0648.

Thank you for your interest on behalf of Mr. Tindle.

Sincerely yours,

Barry Jackson
Director

STATEMENT OF

DAVID M. TUCKER

SENIOR ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON BENEFITS OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

BENEFITS-RELATED LEGISLATION

PENDING BEFORE THE SUBCOMMITTEE

JULY 10, 2001

Chairman Simpson, Ranking Member Reyes, members of the Subcommittee, on behalf of the Paralyzed Veterans of America (PVA) I am pleased to present our views on benefits-related legislation pending before the Subcommittee on Benefits.

Veterans' benefits must be looked at as a means for a nation to recognize and reward the service of its veterans as well as to encourage future generations to serve with the promise that these benefits will be there for them. The benefits measures we will address today send a message, a message meant to assure the men and women who serve in our Armed Forces that we shall not forget their sacrifices, or their service.

For veterans to receive benefits earned by their service, and their sacrifices, they must first be made aware of them. Two measures, **H.R. 1435**, the "Veterans' Emergency

Chartered by the Congress of the United States
801 Eighteenth Street, NW ★ Washington, DC 20006-3517
phone (202) 872-1300 ★ tdd:(202) 416-7622 ★ fax:(202) 785-4452 ★ www.pva.org

Telephone Service Act of 2001," and **H.R. 1746**, a bill to require the Department of Veterans Affairs (VA) to establish a single toll-free telephone number to ensure public access to veterans benefits counselors, are attempts to accomplish this important goal. PVA has concerns regarding both of these measures.

At this time, PVA is unable to support either H.R. 1435 or H.R. 1746. We note that the VA already has a toll-free telephone number to respond to informational requests. In addition, we believe that the VA should operate any informational hotline that is created in addition to the service it currently operates: the VA has the expertise, and the mandate, to accurately answer informational requests and to assist veterans with their benefits claims. More can be done to make the general public aware of this resource, and more can be done to improve it. We call on the VA to move forward to address the concerns underlying these two measures. By working closely with this Subcommittee and veterans' groups, the VA will be better able to improve its informational resources and make available its expertise in veterans' benefits to veterans and the general public.

It is projected that this year an estimated 10 percent of all Vietnam veterans may suffer from diabetes mellitus, also known as Type 2 diabetes. In the past, they have had to bear the financial burden of this disease because it was not recognized as a service-connected disability. As mandated by the VA, effective on July 9, 2001, Type 2 diabetes will be added to the growing list of disease that are presumed to be service-connected as a result of exposure to herbicides.

Recognizing the need of those effected by Type 2 diabetes is paramount to successfully improving their quality of life. PVA does not oppose **H.R. 862**, but we feel it is unnecessary given the actions undertaken by the VA, and currently authorized and mandated by title 38, to establish by regulation the presumption of service-connection for veterans effected by Type 2 Diabetes. The VA, acting under authority granted in 38 U.S.C. § 1116, determined that there is an association between herbicide exposure and Type 2 diabetes based upon reports of the National Academy of Sciences. Therefore, the

goal of the legislation, to provide a presumption of service-connection for Type 2 diabetes, has already been accomplished.

PVA does not oppose **H.R. 1406**, the "Gulf War Undiagnosed Illness Act of 2001." We have stated in testimony before the Senate that we do not oppose S. 409, the "Persian Gulf War Illness Compensation Act of 2001." We believe that a more inclusive definition of an "undiagnosed illness," as found in 38 U.S.C. § 1117, is necessary and we note that Section 2 of H.R. 1406 is a meaningful step forward in accomplishing this goal. PVA also believes that action must be taken to extend the presumptive period, currently slated to end on December 31, 2001. We are aware that the VA is undertaking a review under authority granted in 38 U.S.C. § 1117(b) to determine if the presumptive period should be extended. If the VA decides that this period should not be extended, then we believe that prompt legislative action will be necessary. PVA does not oppose Section 3, which grants authority to the VA to provide for the participation of Persian Gulf veterans in research projects without fear that information garnered during the course of the research project will be used in adjudicating their entitlement for compensation benefits. PVA believes that this is acceptable as long as the veteran has granted his or her full and informed consent to participate in the research project.

PVA supports **H.R. 1929**, the "Native American Veterans Home Loan Act of 2001." Since the inception of this pilot program in 1992, and its extension from 1997 to December 31, 2001, 233 Native American veterans, residing on trust lands, have been able to achieve the dream of home ownership. We believe, as we have testified before the Senate that this successful pilot program should be made permanent. We believe that Section 3 of this measure, authorizing the use of other federal memoranda of understanding is an innovative idea that could mean more Native Americans taking advantage of this program. We believe that the reporting requirements, contained in 38 U.S.C. § 3762 (j) should also be extended through 2005, or, if this program is made permanent, as PVA recommends, extended indefinitely. These reporting requirements are slated to expire in 2002.

The National Service Life Insurance (NSLI) program was available between 1940 and 1951. Twenty-two million policies were issued, of which 1.9 million are still in force. The average age of policyholders is 74. The United States Government Life Insurance (USGLI) program was available between 1919 and 1951. Currently, there are fewer than 20,000 policies in force, and the average age of policyholders is 81. **Section 1 of H.R. 2359** would provide a mechanism for the payment of insurance proceeds of policies issued under these two programs when the first beneficiary cannot be identified.

PVA has concerns regarding this section. Many designated beneficiaries may not even be aware that they are beneficiaries, and hence would not be able to make a claim within the two year time period established by this legislation. In addition, this section grants too much discretion to the Secretary to determine who may be "equitably entitled to the proceeds of the policy." PVA believes that the wishes of policyholders should be followed as far as is practicable. Perhaps the VA should be more aggressive in locating and notifying beneficiaries.

program should be made permanent. We do not oppose granting an extension, and we recommend that the reporting requirements, due to expire next year, be made to run permanently or through 2005. PVA does not oppose subsection (c) of Section 2.

Finally, PVA does not oppose **Section 3 of H.R. 2359**. This section would eliminate the requirement for providing a copy of the Notice of Appeal filed with the Court of Appeals for Veterans Claims with the VA.

PVA supports **H.R. 2361**, the "Veterans' Compensation Cost-of-Living Adjustment Act of 2001." We do oppose again this year, as we have in the past, the provision rounding down to the nearest whole dollar compensation increases.

The way we treat veterans today will either encourage or discourage the men and women currently contemplating service. This is why it is so important that benefits promised be

delivered, and that these benefits maintain their original goals, and their original intentions. The availability, as well as the scope, of benefits sends a clear message concerning the importance of military service to this Nation, to those who are veterans and to those who will be veterans in the future.

This concludes PVA's testimony concerning benefits-related legislation before this Subcommittee. I will be happy to answer any questions that this Subcommittee may have.

DAVID M. TUCKER

David M. Tucker is the Senior Associate Legislative Director for the Paralyzed Veterans of America (PVA), a non-profit veterans service organization chartered by the United States Congress. Mr. Tucker has been with PVA since 1993. He is responsible for federal legislation and government relations, including budget and appropriations; tax policy; health care; medical research; compliance with non-profit tax statues, the Lobby Disclosure Act, gift and ethics rules, and campaign finance provisions; and general legal, judicial, and constitutional issues. He writes regularly for *Paraplegia News*. Prior to coming to PVA, Mr. Tucker was a staff member in the Office of the President and Vice President-Elect and briefly served as a staff member in the Executive Office of the President. While attending law school, Mr. Tucker was a Summer Associate with Central Virginia Legal Aid, served as a Staff Editor of the *Colonial Lawyer* (currently the *Bill of Rights Journal*) and was elected Treasurer of the Student Bar Association. Mr. Tucker has also been affiliated with the Colonial Williamsburg Foundation and the investment house of A.G. Edwards & Sons, Inc..

Mr. Tucker holds degrees from the University of Utah (B.A. 1988) and the College of William & Mary, Marshall-Wythe School of Law (J.D. 1991). He is a member of the Virginia Bar and the American Bar Association. He currently resides in Washington, D.C..

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $83,000 (estimated as of February 28, 2001).

Fiscal Year 2000

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Federal Aviation Administration – Accessibility consultation -- $12,500.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $200,000.

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SERVING
WITH
PRIDE

TESTIMONY

Submitted by
RICHARD JONES
AMVETS NATIONAL LEGISLATIVE DIRECTOR

before the
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON BENEFITS
U.S. HOUSE OF REPRESENTATIVES

on
VETERANS' BENEFITS LEGISLATION

Tuesday, July 10, 2001

A M V E T S

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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

AMVETS is pleased to present testimony on proposed veterans' benefits legislation. We deeply appreciate the commitment of this Subcommittee and its members to address the concerns of veterans.

The discussion today addresses a number of benefit programs affecting nearly every aspect of veterans' lives from health benefits to cost-of-living adjustments as well as making an 800-telephone call to VA.

AMVETS supports the legislative measures before this committee. We believe that approval of these bills would enhance and improve service-connected benefits and services for American veterans and their families.

H.R. 862, to add Type 2 diabetes to the list of diseases presumed to be service-connected for veterans exposed to certain herbicide agents:

AMVETS supports this legislation. Last November, the Academy of Sciences' Institute of Medicine reported a "limited" evidence between adult onset, or Type 2, diabetes and Agent Orange defoliant used in Vietnam. The Department of Veterans Affairs followed the IOM report announcing that it would accept benefits claims if a veteran served in the Republic of Vietnam during the War period, making the disease presumptively service-connected. H.R. 862 would list the disease as being associated with Agent Orange. Because the defoliant was also used along the southern boundary of the Korean Demilitarized Zone, AMVETS reads the legislation to include U.S. personnel deployed to Korea when Agent Orange was sprayed in 1968 and 1969.

H.R. 1406, the Gulf War Undiagnosed Illness Act of 2001:

AMVETS recognizes that, ten years after driving Iraq from Kuwait, many Desert Storm veterans continue to suffer from debilitating ailments that medical science cannot

accurately diagnose. Nearly 1 of every 7 military personnel who served in the Gulf has sought federal help for illnesses they think stem from exposure to prescribed drugs or chemical warfare agents used in the region. Despite enactment of legislation in 1994 to compensate veterans for unexplained multiple symptom illnesses, there exists today a seventy-five percent denial rate for Gulf War veterans seeking help. AMVETS supports America's veterans. We ask only that those men and women who were adversely affected be provided appropriate medical and psychological services. They were healthy and strong when they protected our overseas interests, now they face serious and unexplainable illness. H.R. 1406 would clarify the definition of "undiagnosed," and help provide appropriate care and just compensation for Gulf War veterans.

H.R. 1435, to award grants to provide for a national toll-free hotline to provide information and assistance to veterans:

Amvets supports the establishment of a national toll-free telephone service to VA for veterans and dependents. Making an inquiry to VA is sometimes sluggish and oftentimes frustrating. The establishment of a national information and assistance hot line could serve to further strengthen VA's integrity for veterans' service. While we do not understand why the operation of the hotline should be conducted by "a private, nonprofit entity," we feel such a service would compliment a series of 800-services already available to veterans and dependents, including the following: VA Benefits 1-800-827-1000, Life Insurance 1-800-669-8477, Debt Management Center 1-800-827-0648, CHAMPVA 1-800-733-8387, Headstones and Markers 1-800-697-6947, and the Persian Gulf Hotline 1-800-PGW-VETS among others.

H.R. 1929, the Native American Veterans Home Loan Act:

AMVETS supports the extension of the Native American Veterans Housing Loan Program that provides direct loans to veterans living on trust lands. This bill would extend the pilot program that began in 1993 to December 31, 2005. Without such legislation it would

expire on December 31, 2001. The program was a good idea when it was begun and it continues to serve an important segment of the veterans' community.

AMVETS supports passage of **H.R. 2359**, to authorize payment of National Service Life Insurance and United States Government Life Insurance proceeds to an alternate beneficiary when the first beneficiary cannot be identified, to improve and extend the Native American veteran housing loan pilot program, and to eliminate the requirement to provide the Secretary of Veterans Affairs a copy of a notice of appeal to the Court of Appeals for Veterans Claims. Regarding **Section 1,** AMVETS would inquire of the Subcommittee as to whether VA provides notice to the first beneficiary on entitlement to payment of the insurance proceeds following the death of the insured. Regarding **Section 2,** AMVETS agrees that it is entirely appropriate that the VA or "its authorized agent" approve assumption of the original loan. Such agreement is critical to the program's integrity. AMVETS has no position on **Section 3**, eliminating notice of appeal to the Secretary.

AMVETS supports **H.R. 2361**, the Veterans' Compensation Cost-of-Living Adjustment Act of 2001. This legislation would increase the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for certain disabled veterans and dependents. While we strongly believe that the rate adjustment should be established yearly at a more generous margin than the percentage rate increase established annually under Title II of the Social Security Act, we support this legislation. Clearly, Congress must adjust these rates to avoid eroding their value.

AMVETS sincerely appreciates the opportunity to submit our viewpoint on these issues, and we, again, thank the Subcommittee for its vigilance in improving benefits and services to veterans and their families.

Richard "Rick" Jones
National Legislative Director

Richard "Rick" Jones joined AMVETS as the National Legislative Director on January 4, 2001. As legislative director, he is the primary individual responsible for promoting AMVETS legislative, national security, and foreign affairs goals before the Departments of State, Defense, and Veterans Affairs, and the Congress of the United States.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas, Fitzsimmons General Hospital in Denver, Colorado, and Moncrief Community Hospital in Columbia, South Carolina. At Moncrief Hospital, Rick was selected to assist in processing the first members of the all-volunteer Army.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as committee staff for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans' Affairs, he served two years as Republican minority staff director for the subcommittee on housing and memorial affairs and two years as Republican majority professional staff on funding issues related to veterans affairs' budget and appropriations.

Rick and his wife Nancy have three children, Sarah, Katherine, and David, and reside in Springfield, Virginia.

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Submitted by

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Director, Veterans Benefits Program

accompanied by

Rick Weidman
Director, Government Relations

Before the

United States House of Representatives
Committee on Veterans' Affairs
Subcommittee on Benefits

Regarding

Various Veterans Benefits and Services-Related Legislation

H.R. 862, H.R. 1406, H.R. 1435, H.R. 1746,
H.R. 1929, H.R. 2359, H.R. 2361
and other related issues

July 10, 2001

Vietnam Veterans of America Veterans Benefits and Services-Related Legislation
July 10, 2001

Mr. Chairman and other distinguished members of the Committee, on behalf of Vietnam Veterans of America (VVA), we are pleased to have this opportunity to present our views with respect to several important pieces of veterans benefits and services-related legislation. In this statement, we will address each proposed bill *seriatim*. VVA is most appreciative of your inviting us to testify and to provide a statement for the record in this matter, as well as and for your leadership in seeking to improve such a vital VA programs as those affected by the legislation at issue.

H.R. 862 – Presumptive Service Connection for Diabetes Mellitus (Type II).

Almost a decade ago, Congress passed Public Law 102-4, the "Agent Orange Act of 1991". *See* 38 U.S.C. § 1116. The Act provided the Secretary of Veterans Affairs with the authority to establish presumptive service connection (*i.e.*, entitlement to service connection for diseases without the necessity of medical evidence to establish an etiological nexus between military service and a current disease) for diseases that have been scientifically demonstrated to be associated with exposure to the chemical defoliant Agent Orange, dioxin and other herbicidal agents during military service in Vietnam. Whenever the Secretary determines, on the basis of sound medical and scientific evidence, that a "positive association" exists between such exposure and the subsequent occurrence of disease, the Secretary shall prescribe regulations providing that a presumption of service connection is warranted for such disease. *See* 38 U.S.C. § 1116(b)(1). In making such a determination, the Secretary has been directed to take into account both reports received from the National Academy of Sciences (NAS) and "all other sound medical and scientific information and analyses available to the Secretary." 38 U.S.C. § 1116(b)(2). The association between disease and exposure is considered to be positive if "credible evidence for the association is equal to or outweighs the credible evidence against such association." 38 U.S.C. § 1116(b)(3).

Until recently, nine diseases were presumptively considered to be the result of exposure to herbicidal agents used in Vietnam during the war: chloracne or other acneform disease consistent with chloracne; Hodgkin's disease; acute and subacute peripheral neuropathy; porphyria cutanea tarda; multiple myeloma; non-Hodgkin's lymphoma; prostate cancer; respiratory cancers (*i.e.*, cancer of the lung, bronchus, larynx or trachea); and certain specified soft-tissue sarcomas. *See* 38 C.F.R. § 3.309(e). Moreover, exposure to these agents has been shown to be so detrimental that VA healthcare, vocational training and a monetary allowance are available for *children* of Vietnam veterans who suffer from spina bifida. *See* Pub. L. 104-204, § 402. In addition, the VA has announced that based upon NAS's Institute of Medicine's (IOM) recent findings, benefits will soon become available for children of Vietnam veterans who have acute myelogenous leukemia (AML).

In April and October, 2000, VVA petitioned the Secretary of Veterans Affairs to promulgate regulations to provide presumptive service connection for diabetes mellitus (Type II) as the result of exposure to Agent Orange and other herbicidal agents. Veterans have been severely affected by this disease for years without both well-deserved compensatory relief and desperately needed health care. In its latter petition, VVA specifically requested the Secretary to add adult–onset diabetes to the list of diseases that are presumed to be related to herbicidal exposure during the Vietnam War. Previously, he had deferred doing so pending the results of the IOM's reevaluation of the relationship between such exposure and the subsequent development of that disease. In view of the IOM's October 11, 2000, announced determination that there exists "new 'limited or suggestive' evidence" of an association in this respect, it became clear that the time had come for the VA to establish presumptive service connection for diabetes mellitus. There was now sufficient medical and scientific evidence to establish a positive association and a biological mechanism between exposure to Agent Orange/dioxin and adult-onset diabetes mellitus. Consequently, this new evidence is, at minimum, equal to, or, in our opinion, outweighs, evidence against such association.

On May 8, 2001, the VA published a final rule in the Federal Register that would add diabetes mellitus (Type II) to the list of diseases that are afforded presumptive service connection as the result of exposure to Agent Orange. *See* 66 Fed. Reg. 23,166 (May 8, 2001). *See also* 38 C.F. R. § 3.309(e). Because of the substantial economic impact of this new regulation (estimated at more than $3 billion dollars over the next five years due to the large number of Vietnam veterans afflicted with diabetes mellitus (Type II)), the effective date of the regulation was established as July 9, 2001 (in conformance with the provisions of the Congressional Review Act of 1996, 5 U.S.C. § 802).

At first glance, H.R. 862, which would amend 38 U.S.C. § 1116(a)(2) by adding diabetes mellitus (Type II) to the Agent Orange-related presumptive disease list, would appear to be somewhat moot in light of the VA's new regulation. Nevertheless, VVA urges the swift passage of this legislation to preclude the VA from removing or curtailing this new disability benefit in the future. Moreover, we would encourage Congress to add much more to this bill.

In its May 8, 2001, notice in the Federal Register, the VA addressed two aspects concerning subsequent awards of presumptive service connection for diabetes mellitus (Type II). VVA takes exception with the VA's decision in this respect. First is the issue of extending this presumption to those service personnel who were exposed to Agent Orange and other herbicidal agents during their military service, but not actually within the geographical boundaries of the Republic of Vietnam. Specifically, we are referring to exposure in the territorial waters of that country and in other locations where there was documented use of agent Orange (*e.g.*, Panama, Korea and Fort Drum, New York).

Pursuant to 38 U.S.C. § 1116(a)(3), there is a presumption of exposure to Agent Orange and other herbicides for any service personnel that actually served in the Republic of Vietnam. This presumption stems from the difficulties encountered in securing evidence to demonstrate that an individual was actually exposed. The presumption applies not only to personnel on the ground during and after aerial spraying, but those individuals that loaded the aircraft with herbicides or otherwise came into contact with toxic chemicals. Currently, 38 U.S.C. § 1116 requires that a veteran have served in the "Republic of Vietnam" in order to be eligible for the presumption of exposure to herbicides. While the VA has acknowledged that this statute encompasses service on this inland waterways in Vietnam, 38 C.F.R. § 3.307(a)(6)(iii) provides that service in the Republic of Vietnam includes service in offshore waters or other locations only if the conditions of service involved duty or visitation within the Republic of Vietnam. In a VA General Counsel precedent opinion, similar language in 38 U.S.C. § 101(29)(A) was determined to mean that service in a deep-water vessel in waters offshore of the Republic of Vietnam does *not* constitute service in the Republic of Vietnam. *See* VA OGC Prec. 27-97. Since the VA's regulatory definition of "Service in the Republic of Vietnam'" predates the enactment of § 1116(a)(3) (*see* former 38 C.F.R. § 3.311a(a)(1)(1990)), the VA general Counsel opined that there is no basis upon which to conclude that Congress intended to broaden that definition through § 1116(a)(3). The VA has further rejected offshore coverage due to a lack of evidence that individuals who served in the waters offshore of the Republic of Vietnam were subject to the same risk of herbicide exposure as those who served within the geographic boundaries of the Republic of Vietnam, as well as the notion that offshore service is within the meaning of the statutory phrase "Service in the Republic of Vietnam. The VA's one nod to offshore service is the extension of the presumption of exposure if the ship docked within Vietnam and the veteran had actually disembarked and stepped ashore.

Extrapolating from the foregoing line of analysis, it is evident that the VA would also reject presumptive service connection for those who were exposed to herbicidal agents during their service in other venues, such a Panama, Korea and Fort Drum.

Accordingly, VVA encourages Congress to amend 38 U.S.C. § 1116(a)(3) to apply the presumption of exposure not only to service in the Republic of Vietnam, but also to service in the waters offshore, as well as for anyone serving in any other location where the use of herbicidal agents has been generally documented.

The second issue of concern is the VA's position on the retroactivity of awards of presumptive service connection for Agent Orange-related diabetes mellitus (Type II). For years, veterans have been filing claims for service connection for this disorder with

and without specific medical evidence of an etiological nexus to toxic exposure. In 1999, the CAVC handed down a decision wherein it opined that 38 U.S.C. § 1116(a)(3) and 38 C.F.R. § 3.308(a)(6)(iii) authorize the presumption of exposure only if the veteran has been diagnosed with one of the VA-approved presumptively service-connected diseases. *See McCart v. West*, 12 Vet.App. 164, 168-169 (1999). The VA quickly embraced this decision, resulting in the denial of veterans' claims for service-connection for diseases not on the presumptive list, even where there was competent medical evidence of an etiological nexus between exposure to herbicides in Vietnam and the subsequent onset of the disease. In our experience, the VA routinely denies such claims, regardless of any probative evidence submitted in support thereof. In other words, there is little or no consideration of service connection on a direct, rather than a presumptive, basis. VVA strongly supports the restoration of the critical presumption of exposure *vis-à-vis* all presumptively service-connected diseases and those sought on a direct basis through competent medical evidence. This is of particular importance with respect to diabetes mellitus (Type II); a particularly insidious disorder.

If exposure is presumed and the veteran had filed a claim for service connection for diabetes mellitus (Type II) prior to July 9, 2001 (the effective date of the aforesaid final regulation on presumptive service connection for that disorder), there is no reason why the effective date of an award of service connection should not be established retroactively to the date of the VA's receipt of the original claim for service connection. *See, generally*, 38 U.S.C. § 5110(a); 38 C.F.R. § 3.400. The problem is that 38 U.S.C. § 1116(c)(2) provides that VA regulations promulgated as a result of the Secretary of Veterans Affairs' conclusion that a positive association exists between exposure to herbicidal agents and a specified condition or disease "shall be effective on the date of issuance" of the regulation. In view of 38 U.S.C. 1116(c)(2) and 5110(g), the VA apparently does not have the authority to provide for a regulatory assignment of an effective date earlier than the date on which the rule was issued (here, effectively July 9, 2001).

VVA maintains that in order to ameliorate the inequity of delayed recognition of the impact of service-connected diabetes on the lives of veterans and their families, Congress should include in H.R. 862 a provision establishing an effective date for presumptive service connection retroactive to the date of an original claim for service connection for that disorder. We believe that such a directive would be consistent with the case of *Nehmer v. U.S. Veterans Administration*, C.A. No. C-86-6160 (TEH) (N.D. Cal.) (awards of disability compensation or dependency and indemnity compensation (DIC) made pursuant to VA regulations issued on the basis of 38 U.S.C. § 1116 may, under certain circumstances, be made retroactive to the date of an earlier claim that was filed before the issuance of such regulations).

There can be no doubt that veterans who served in Vietnam faced exceedingly more than the dangers associated with hostile action. The environment in which they lived, fought and died teemed with toxic chemicals and endemic diseases. Much has been accomplished in recognizing this basic truth, but there is a long way to go. Vietnam veterans incur diseases of old age many years sooner than those of similar age who did not serve there. Adult-onset diabetes mellitus, generally with no prodromal manifestations during service, is a prime example of this phenomenon. Vietnam veterans are dying of this disease. Often, they go without medical treatment because of financial difficulties. For these veterans, presumptive service connection not only means receiving disability compensation, but also entitlement to life-saving VA medical care.

Most medical professionals and scientists would agree that we have only scratched the surface with respect to understanding the long-term effects of toxic exposures, including dioxin. Many of the current studies heavily relied on by the IOM and the VA (*e.g.*, the U.S. Air Force's Ranch Hand study) are woefully inadequate to present a true picture of the devastating effects of such exposure. Findings are gender biased since most of the populations studied consist entirely of males. Other studies extrapolate conclusions merely from the examination of dirt and fish. More funding and research is required to even approach the level of understanding to treat and compensate our suffering veterans.

The medical panel of the Institute of Medicine of the national Academy of Sciences that reported the bi-annual review this past Spring specifically told VVA, in response to our direct question, that the lack of ongoing large scale epidemiological studies of Vietnam veterans and their offspring was a significant detriment to their work, and prevented them from doing the type of work called for due to the seriousness of these issues. VVA calls on this Committee to take the leadership in mandating a reopening of the "Vietnam Generation study" by the Centers for Disease Contol (CDC), with proper leadership this time and sufficient oversight by a civilian advisory panel. VVA also calls on the Congress to ensure that the so-called Vietnam Readjustment Study, mandated by the Congress last year, include a full physical with blood serum dioxin testing.

VVA also urges the Congress to make available significant funding for dioxin and "in country effect" studies of possible adverse health effects of exposure to herbicides and other toxic substances used by the United States in Vietnam. There needs to be many such studies conducted by respected independent private researchers proceeding simultaneously in order to get the answers Vietnam veterans and their families need and deserve before we are all dead. There is not a single ongoing study funded by VA at this point, nor any such studies of Vietnam veterans funded by the National Institutes of Health.

VVA therefore urges Congress to consider and to pass further legislation to assist dying and seriously ill veterans who have been so severely affected by the use of chemicals in Vietnam and other locales.

H.R. 1406 – Gulf War Undiagnosed Illness Act of 2001.

The purpose of this bill is to improve presumptive disability compensation benefits for veterans who suffer from poorly-defined illnesses as the result of their service during the Persian Gulf War. Section 2 of the bill would amend 38 U.S.C. § 1117(a) by expanding the description of undiagnosed illness for which the VA may provide compensation to include fibromyalgia, chronic fatigue syndrome, a chronic multi-symptom illness, or any other poorly-defined illness (or a combination of poorly-defined illnesses). Obviously, VVA strongly supports this enhanced description, since experience has demonstrated that the VA Compensation and Pension (C&P) Service has historically interpreted the existing statutory language as narrowly as possible.

Section 3 of H.R. 1406 would add subsections (g)(1) and (2) to 38 U.S.C. § 1117 which would protect the continuation of awards of service-connected disability compensation for Persian Gulf War veterans who participate in VA-sponsored medical research projects. Specifically, the legislation would preclude any medical information that is directly or indirectly derived from such participation from being considered in the process of adjudicating a claim for the veteran's entitlement to receipt of service-connected disability compensation. While VVA favors this prohibition, we believe that there should be specific language in the bill to direct the Secretary of Veterans Affairs to take affirmative measures to ensure that VA adjudicators do not have access to diagnostic or clinical documentation or other information generated by a veteran's participation in these studies. Such language would help to ensure that such information does not makes it way to the adjudicators and avoid the possibility of its influencing their benefits determinations.

VVA would also like to take this opportunity to address a few other important Persian Gulf War healthcare and benefits issues. VVA vigorously supports H.R. 612 and its Senate counterpart, S. 409, concerning compensation for Persian Gulf War illnesses. In its June 28, 2001, testimony before the Senate Committee on Veterans' Affairs, VA officials asserted that there is no need for such legislation, since existing authorities are sufficient to deal with Gulf War-related claims (*e.g.*, service connection on a direct basis). VVA, however, believes the case to be otherwise. Passage of this legislation is critical if ailing Gulf War veterans are to receive the compensation for the broad spectrum of medical problems as a result of their service in Desert Storm.

It is VVA's opinion that the VA has restrictively interpreted the intent of Congress as embodied in the original legislation passed to help ill Desert Storm veterans obtain compensation for undiagnosed illnesses. *See* the Persian Gulf War Veterans' Benefits Act, Pub. L. 103-446. Apparently, our opinion is shared by former chairman of the House Veterans' Affairs Committee, Rep. Bob Stump.

In a June 3, 1998, letter to then-VA Secretary Togo West, Chairman Stump stated, in part:

> "...it has become increasingly apparent to us that the Department is too narrowly implementing the landmark legislation initiated in this Committee to provide compensation for these veterans."

In critiquing the VA's implementing regulation (38 C.F.R. § 3.317), Mr. Stump noted that:

> "VA regulations implementing that law...effectively limit compensation to "illness...[which] by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis...in ruling out compensation under PL 103-446 in any case where the illness in question has been given a diagnosis is to ignore both the nature of the illnesses Congress sought to have the VA compensate as well as the philosophy of benefits adjudication it sought to have the Department apply."

In the three years that have passed since Mr. Stump issued this letter, the VA's own statistics tell the tale of how the Department has failed to properly compensate ailing Gulf War veterans. According to the Veterans Benefits Administration's Data Management Office, as of January 2001, the VA was denying undiagnosed illness claims under PL 103-446 at a rate of approximately 75%. In other words, *three out of four Desert Storm veterans who have filed undiagnosed illness claims have been denied benefits*. This statistic alone speaks volumes with respect to VA's attitude toward the validity of the relationship between service in the Gulf War and the onset of subsequent poorly defined illness.

Moreover, the VA's assertion that ill Desert Storm veterans can achieve direct service-connection for their undiagnosed illnesses is simply untrue in the overwhelming majority of cases. In general, VA grants direct service-connection for disease or injury incurred during active military service where there is evidence of incurrence or onset during service, where there is a current diagnosis and where there is competent medical evidence of a nexus between the two. In the absence of any applicable presumption, all three requirements must be satisfied. Nevertheless, the Department of Defense has repeatedly acknowledged that its medical record keeping during and after Desert Storm was abysmal. Thus, even if a veteran reported seemingly inexplicable symptoms during the conflict, it is unlikely that such conditions were documented at the time. In addition, the overwhelming majority of ill Desert Storm veterans developed their symptoms *after* the war, thereby virtually guaranteeing their ineligibility for direct service connection.

Legislation such as H.R. 612 and S. 409 will alleviate these difficulties by clearly defining Congress' intent to ensure meaningful VA benefits and services for our Gulf War veterans. We further recommend that the lack of definitive scientific evidence

concerning the onset time of Gulf War-related illness justifies leaving the presumptive period for service connection for Gulf War illness indefinitely open. As we have previously testified, there is no scientific basis whatsoever for placing any type of time limit on the manifestation of such illnesses.

We also recommend that the Committee hold an oversight hearing (this Fall, if possible) to examine the health and compensation ramifications of the latest research into Gulf War illnesses. We specifically recommend that the Committee request presentations from the General Accounting Office on their April 2001 report, *Coalition Warfare: Gulf War Allies Differed in Chemical and Biological Threats and in Use of Defensive Measures* (GAO-01-13, April 2001). This report notes that French Gulf War veterans suffer virtually no symptoms of Gulf War illness in comparison to their American and U.K. counterparts. They key difference between the French and U.S./U.K. approach to chemical/biological defense during the Gulf War was that the French did not use biological warfare vaccines on their forces. VVA believes that in light of this GAO finding, and on the basis of widespread reports of serious adverse reactions among American military personnel to the anthrax vaccine over the past three years, that the committee should fully investigate whether chemical/biological warfare medications may have produced "medical fratricide" among our Gulf War and later era veterans.

Additionally, with respect to future funding of Agent Orange, Gulf War, and other medical research and treatment studies, VVA strongly urges this Committee to establish (preferably under the auspices of the Department of Health and Human Services) a peer-review panel that includes *voting* representatives of the veteran service organizations. A potential model for this is the Congressionally Directed Medical Research Programs (http://cdmrp.army.mil), which includes patient advocates on its peer-review panels charged with making decisions about which research or treatment programs will receive funding in the areas of breast and prostate cancer research, among others.

VVA strongly believes that the existing Military and Veterans Health Coordinating Board (MVHCB) (the entity that currently has jurisdiction over the Gulf War Illness (GWI) research and treatment funding program) is both exclusionary and out of touch with the legitimate concerns of veterans and their family members about the nature, scope, and direction of research and treatment for toxic battlefield exposures. For example, the current ratio of GWI research versus treatment programs is approximately *100 to 1* (*i.e.*, the MVHCB has funded only two treatment programs over the past seven years).

Establishing a veteran-inclusive peer-review panel that examines *all* past toxic battlefield exposure issues is the best mechanism for ensuring both sound scientific results and addressing the legitimate concerns of veteran-stakeholders. Establishing such an entity within HHS would ensure that specialized agencies, such as the National

Institutes for Environmental Health Sciences, are fully integrated into medical research and treatment programs involving veterans, something that is currently not the case. Only by utilizing the full medical resources of the federal government in a rational, stakeholder-inclusive fashion can we hope to properly diagnose and treat the medical conditions afflicting Vietnam, Gulf War, and other post-Cold War veterans.

Finally, VVA urges the Congress to compel the Secretary to improve VA's outreach to Gulf War veterans nationally, specifically through a television advertising campaign or televised public service announcements. VVA and its sister organization, the National Gulf War Resource Center, continue to receive phone calls, e-mails, and letters on a weekly basis from Gulf War veterans who have absolutely no idea what VA programs are available to them. Despite the perception that we live in an age of instant, internet-based communications, many veterans, particularly those who are homeless or who live in rural communities, do not have routine access to or familiarity with the internet. These veterans do, however, have access to television and print media. The VA should be using that as its primary medium for outreach to veterans of *all* eras.

H.R. 1435 and H.R. 1746 – Veterans' Emergency Telephone Service Act of 2001 and Creation of a Single "1-800" telephone Number for VA Benefits Information.

H.R. 1435 would provide the VA with the authority to award two-year monetary grants to qualifying private, nonprofit entities for the operation of a national, toll-free telephone number to provide information and assistance to veterans and their families. Services would include crisis intervention counseling and general information pertaining to veterans' and dependents' benefits, emergency shelter and food programs, substance abuse rehabilitation, employment and training opportunities, as well as small business assistance programs. H.R. 1746 would amend the veterans assistance office provisions of 38 U.S.C. § 7723 by requiring the VA to establish a single, nationwide toll-free "1-800" telephone number for public access to VA veterans benefits counselors. The bill further directs the Secretary to ensure that these counselors have available to them information concerning veterans benefits provided by the VA and all other departments and agencies of the United States, as well as those provided by State governments.

VVA enthusiastically supports both of these bills. One of the major criticisms continually presented to us by our veteran and dependent clients, as well as from our accredited service representatives, is that it is often quite difficult, if not nearly impossible, to get through to the VA regional offices to discuss benefits-related generalities and specifics. The current VA toll-free number automatically routes the call to the VA regional office nearest the caller. The caller is then presented with a huge menu of routing options. The current system is inefficient, uninformative and, often, very frustrating. Waiting times to speak to a live person are inordinate and met with unending transfers that frequently terminate in the system hanging up on the caller. This

local routing system does a claimant no good if they are calling with a claims-specific inquiry from out of town, and the system routes the call to a regional office other than the inquirer's. A single, nationwide toll-free number, with knowledgeable operators and counselors would go a long way to rectify these communications problems.

H.R. 1929 – Native American Veterans Home Loan Act of 2001.

This bill would extend the current Native American veterans housing loan pilot program, currently set to expire in 2001, through 2005. The program encompasses direct home loans to Native American veterans living on trust lands. VVA is enthusiastically endorses this action, but would request that given the intentions behind this program, its pilot nature should be made permanent and the program extended indefinitely. We would further urge the retention of the requirement that the VA outstation part-time VA loan guaranty specialists at tribal facilities upon request by the tribe.

H.R. 2359 – Alternate NSLI and USGLI Beneficiaries; Extension of Native American Housing Loan pilot Program; Service of Notice of Appeal in CAVC Cases.

Section 1(a) and (b) of this bill would allow for the payment of insurance proceeds under the National Service Life Insurance (NSLI) and the United States Government Life Insurance (USGLI) programs to a secondary beneficiary that has been designated by the insured in the event that the first (primary) beneficiary does not file a claim for such payment within two years of the date of the insured's death. *See* 38 U.S.C. §§ 1917 and 1951. If no claim is made within four years from the date of the insured's death, and there has been no written notification such a claim will be made, the Secretary would be authorized to issue the proceeds to any person that the Secretary believes to be equitably entitled to the proceeds. Any disbursement of the insurance proceeds will be considered a bar to recovery by any other person (presumably including a primary beneficiary who does not file a timely claim). VVA is not opposed to these provisions.

Section 2 of the bill essentially mirrors the provisions of H.R. 1929. Our comments with respect to that bill apply to this section as well.

Section 3 of H.R. 2359 would repeal 38 U.S.C § 7266(b), which currently requires that a copy of an appellant's Notice of Appeal to the Court of Appeals for Veterans Claims (CAVC) must be served on the Secretary (*i.e.*, the VA Office of the General Counsel) at the time of filing with the Court. *See also* U.S. Vet. App. R. 3(b) and R. 25(c). The Notice of Appeal is the procedural threshold for obtaining review by the CAVC of an adverse final decision of the Board of Veterans' Appeals. In order for

jurisdiction to confer, the appellant must file a Notice of Appeal within 120 days after the date on which the Board's decision was mailed to him or her. *See* 38 U.S.C. § 7266(a). *See also* U.S. Vet. App. R. 4(a).

From a procedural standpoint, once a Notice of Appeal is filed with the Court, the Clerk of the Court prepares a Notice of Docketing, which is sent to both the appellant and the VA Office of the General Counsel (OGC). *See* U.S. Vet. App. 4(b). The Notice of Docketing advises each party of the next procedural step in the litigation process.

Pursuant to the Court's rules of procedures, however, the 60-day period in which the Secretary must designate the record on appeal does not begin to run until the Court Clerk issues its Notice of Docketing. *See* U.S. Vet. App. R. 10(a). Typically, the VA OGC does not begin the process of designating the record on appeal until it receives the Notice of Docketing (although the OGC might request the appellant's VA claims file from the appellant's VA Regional Office upon receipt of the Notice of Appeal).

Since the VA is not required to takes any action until its receipt of the Notice of Docketing, there would be no practical effect to the rescission of the requirement that the appellant serve a copy of his or her Notice of Appeal on the Secretary. Consequently, VVA does not object to this section of H.R. 2359.

H.R. 2361 – Veterans' Compensation Cost-of-Living Adjustment Act of 2001.

Quite obviously, VVA enthusiastically supports this legislation. Disabled veterans and their families fall victim to the rising costs of living no less so than anyone else. H.R. 2361 would increase the current levels of disability compensation, additional compensation for dependents, the VA clothing allowance and the various rates of Dependency and Indemnity Compensation (DIC). The percentage of increase would be equivalent to the percentage of the cost of living adjustment (COLA) for Social Security beneficiaries, and would become effective as of December 1, 2001. These COLA increases are absolutely necessary to ensure that veterans and their dependents receive meaningful benefits, and to prevent them from falling through inflationary cracks.

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these important pieces of legislation. We believe that they addresses matters of vital concern to veterans, their dependents and the American people. We look forward to working with this Committee and Congress on this and other important issues.

Vietnam Veterans of America
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World Wide Web: http://www.vva.org
A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

VIETNAM VETERANS OF AMERICA

Funding Statement

July 10, 2001

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a § 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any Federal grant or contract, other than routine allocation of office space and associated resources in VA Regional Offices and the Board of Veterans Appeals for outreach and direct services through its Veterans Benefits Program (service representatives). This is also true of the previous two fiscal years.

For further information, please contact:

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Leonard J. Selfon, Esq.
Director, Veterans Benefits Program

Leonard J. Selfon, Esq., has served as the Director of VVA's Veterans Benefits Program since September, 1999. In that position, he is responsible for the training and oversight of more than 400 accredited service representatives nationwide, and supervises VVA's representation of veterans and their dependents before the Board of Veterans' Appeals and the Federal courts. In addition, Leonard serves as a contributing writer and managing editor of VVA's publication *Veterans Benefits News*, which contains the latest information on legislation, regulations and court decisions that affect veterans benefits law. He has also prepared and delivered testimony before Congress concerning a variety of veterans-related issues.

Between 1991 and 1998, Leonard served as counsel to the Secretary of Veterans Affairs, working as a Senior Appellate Attorney in the VA Office of the General Counsel. His primary responsibility was to represent the VA in all aspects of appellate litigation before the U.S. Court of Appeals for Veterans Claims. Upon leaving the VA in October, 1998, Leonard served as a veterans law consultant to both the Veterans Consortium *Pro Bono* Program and to members of the private veterans bar. He has also had experience in the corporate law sector, having served as legal consultant to a national health insurance carrier.

Leonard is a graduate of the University of Maryland and the University of Baltimore School of Law.

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Richard Weidman
Director, Government Relations

Richard Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. He served in the United States Army, as a medic with Company C, 23rd Med, Americal Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as Director of Veterans Employment & Training for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readadjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities on Disabled Veterans, Advisory Committee on veterans' entrepreneurship on the Small Business Administration, and numerous other advocacy posts in veteran affairs.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veteran affairs. He attended Colgate University B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

TESTIMONY TO THE VETERANS AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON BENEFITS
JULY 10.2001

BY

DENISE NICHOLS
VICE CHAIRMAN
NATIONAL VIETNAM AND GULF WAR VETERANS COALITION

The National Vietnam and Gulf War Veterans Coalition, a coalition of 106 member groups including such groups as Viet Now, Rolling Thunder, Vietnam Veterans of the War, Inc, and Gulf War Veterans Groups nationally and internationally, have endorsed S409/HR612 The Gulf War Veterans Compensation Act of 2001.

In the 105th Congress, there were many hearings on the Gulf War Illnesses to include House efforts (Congressman Shay's Government Reform Committee Investigation) and multiple Senate Veterans Affairs Committee Hearings. In the hearings on the senate side at that time there was mention of a need for a blanket disability for the Gulf War Veterans. At the end of the session, legislative action and law was passed to send the Gulf War Veterans to the Institute for Medicine to review the Health consequences of over 20 known exposures. The Institute of Medicine completed their first study in November of last year on the Sarin, Depleted Uranium, PB tablets, and vaccines. Unfortunately, when the Veterans Affairs Administration awarded the contract to the IOM they limited them to the use of only peer reviewed journal articles. This was probably related to national security concerns but it prevented the IOM from requesting and reviewing DOD unpublished research and reports on these exposures, which definitely hurt the gulf war veterans obtain service connection to diseases, known and unknown, related to these exposures. There were similarities seen with the Sarin Gas Victims of the Japan Subway incident.

Anthrax reactions are still being examined by the IOM after the House of Representative (Rep Shays subcommittee on Government Reform and the Full Government Reform Committee) and the door must be kept open for the Gulf War Veterans and for

those that have had health consequences from the Anthrax Vaccine. Research is on going on the interactions of PB tablets and nerve agents and other exposures. Many Federally Funded Research projects are still not reported as completed and published.

We are still receiving inquiries weekly, if not more frequently from Gulf War Veterans both deployed and non-deployed and those that have received Anthrax vaccines who are just now realizing their symptoms and who have not yet reported into the VA or the DOD medical facilities for assistance. The veterans have as normal people, with chronic type disease processes, normal coping going on where if they can they keep continuing to try to do their normal activities and deny their symptoms as long as they can before their bodies can not continue.

In addition, many gulf war veterans remained on active duty and in the reserves and guard despite having symptoms and being ill. But in order to stay in and continue to support their families, they have not reported their symptoms since they see a repeat of the Agent Orange scenario (years past without effective help or disease recognition). Therefore it is imperative that we extend the time presumption to allow them time to come forward, since many are just now leaving the service.

The research and review ongoing at the IOM has not even gotten to the stage of considering the synergistic effects of multiple exposures.

It is imperative that we continue the present coverage for the veterans and extend the time presumption period of time another ten years until 2011. We need to also remember to extend the Priority Care to these veterans as is currently in place.

The symptoms list and the time period of the symptoms to be considered chronic will not be changed in this legislation, the bill simply seeks to codify two separate sections of The 38 CFR USC code (sections 117 and 118) for clarity to the VA adjudicators, in order that the importance of proper review of claims is fully implemented. Too many claims have been denied and the veterans are the ones that suffer unnecessarily. Since 1993, the Sense of the Congress has been to care for the Gulf War Veterans and to enact the benefit of the Doubt to the Veterans! It is to this government's advantage to rectify the errors of the past and to seek adequate and effective compensation for the Gulf War Veterans. The president in his campaign even stated that he did not want the Gulf War Veterans standing in line with hat in hand.

If we do not take these positive steps, the trust and faith in our government by both the active duty and the veterans will suffer. We have seen effects on recruitment and retention due to the fact that our veterans are not as well care for as they should be when they have put their life in harms way and have been damaged. This situation creates a vicious cycle where then the government has to then funnel more money into ads, educational benefits, and other recruitment and retention efforts in order to overcome a negative effect from failure to fully compensate and care for the veterans of a war/conflict.

The other portion of the bill is the effort to direct that every benefit of the doubt goes to the veteran. The symptoms are a constellation of symptoms and normally do not consist of just one or two symptoms, the majority of the veterans have had all of the symptoms listed and the epidemiological surveys have clearly shown that problem.

The last item of the bill 1-b- highlights the overlapping of the symptoms the gulf war veterans have with some of the diagnosed illnesses re Chronic Fatigue, Multiple Chemical Sensitivities, and

other autoimmunological diseases. The Art and Science of Medicine does not guarantee 100 percent accurate or correct diagnosing and therefore if the symptoms are common and overlapping the veterans claims should not be thrown out for Undiagnosed Illnesses if they have received a diagnosis for a known illness that may or may not be an accurate diagnosis. Again, this seeks to give clear legal guidance to the VA adjudicators to give the benefit of the doubt to the veteran.

The Gulf War Veterans are ill and it is real. We should not have the veterans who are ill and need assistance fight their own government for the earned benefit that they EARNED by putting their bodies and life on the line for the United States Government (and its citizens), its national policies and security. We Recommend that this bill be Fast Tracked and passed into law now.

WE must get passed the issue of compensation and into the other needs of the Gulf War Veterans such as complete and accurate diagnostic testing and medical treatment options. We have attached a list of these Identified needs and hope that other Senators and Representatives will take proactive action in these issues.

We would like to recommend that legislative steps be taken for the troops and veterans that did not serve in theater and who are ill, whether it is from anthrax vaccine, other vaccines, pb tablets, or NBC exposures from secondary routes. These veterans have also been waiting for assistance and enacting a registry, priority care, and compensation is the next step. These steps may also help us further the research into undiagnosed illness and find the factor that may have caused the most damage or the key component to their illnesses. WE need to do this for National Security and for the future soldiers of this country and for the Citizens as well.

Thank you for your time and interest at today's hearings. We stand ready to testify in person at the next Senate or House Hearing on the Issuc of Gulf War Vcterans Compensation/Health and Investigations relating to it.

Appendix 1----Gulf War Veterans Needs List
Appendix 2---Exerpts from Presidential Oversight Board Seattle meeting 1999 (Dr A. Vjordani and VFW rep on Rep Stump Letter to Sec of VA)

Appendix II

NEEDS OF GULF WAR VETERANS

1. Presumption of Service connection for Gulf War veterans from the VA Urgent.

2. Need VA to start registry for those GULF WAR VETS THAT WERE Deployed Ready got shots etc and have been ill for 10 yrs! This Database should also include civilian contractors that are ill from gulf war in or out of theater. Database should also be started for those that have since recived anthrax vaccines and are reporting in ill.

3. Regulation enforcement thru DOD and FDA filing of forms ADVERSE Drug Reaction for pb pills, Adverse Reaction to Vaccines(VAERS) Forms! Needs to be written into DOD regulations!

4. Need DOD and VA to make public list of Gulf War Veterans who have died after the war.....Name, state, unit, Date of Death, cause, diagnosis.

5. List of Diagnosed illnesses on ALL gulf War Veterans.

6. Fee Basis at VA for independent testing of GW VETS re Hemex testing, DR Urnovitz Caliptye testing, Immunological screening by DR Ari Vjordani lab in Calif, SPect SCans, MRI-RS testing.

7. Gulf War veterans to be made part of panel for Peer Review Scientific Panel re funding of studies for federal grants.

8. VA and DOD to make public list of grant funding requested turned down and reason.

9. Publish list of Reviewers for federal grants re Gulf War related studies.

10. VA meeting with GW vets once a month or at least quarterly to review problems—OPEN dialogue—VETS to have input to Agenda and discussion fully-open to public. This should be done in DC and at each VA hospital.
Each VA and VA Regional office should form a Gulf War Committee with GW vets included. Each VA should open its door to independent DRS and researchers on GW research and care on Quarterly basis(This meeting is to share openly with VA

doctors and gulf war veterans all theories, potential research, and treatment and testing options).

11. Gulf War veterans office to be formed at VA central office to deal with Claims problems—hot line.

12. Fast track action policy for Claims assistance for GW vets homeless and having to live with parents, etc, and those with family members sick.

13. Assistant for Gulf War issues to include Gulf War Vet medical person.

14. Gulf War veterans(me and others) to be placed on official White House,DOD,VA invitational list.

15. Gulf War veterans to receive free registration at any federally sponsored meeting on GW illness. Assist Gulf War Veterans with travel expense. Hotel rooms deeply discounted at these functions to bare minimum for GW vets.

16. Round table of Gulf War Veterans to be official part of any federally sponsored conference on Gulf War.

17. GW veterans will receive a stipend for phone expenses when they are active advocates and are responding as Hotline for GW Veterans seeking help and feeling suicidial.

18. Emergency Claims approval for GW veterans Set up for a temporary claim approval.

19. Dental Exams and Dental emergency care to be provided by VA and DOD to Gulf War Veterans.

20. Gulf War Veterans need Opthamalogy exams and follow up by VA.

21. Monthly listing of New Gulf War Veterans Deaths by name, unit, state, diagnosis, cause of Death from DOD and VA to be published openly on DOD and VA websites.

22. A truely interactive web sites re VA and DOD re complaints and questions and help assistance from gulf war veterans.....Bulletin Board formate.

23. Fee BASIS for Civilian DR consults for Gulf War Vets liberalized.

24. Reports monthly open from VA re Claims data numbers update on Agent Orange, Atomic Vets, GW vets on internet sites.

25. Educational newsletters with ALL Research(Govt and Independent) for VA Doctors and medical providers(VA, civilian, any gw vet) Bulletin board Email Internet system set up to do this too!(open to public review)

26. NO retaliation to Drs re VA,DOD, civilians or researchers for working on GW issues, speaking up on GW medical concerns, or diagnosising GWS. This should be policy with follow up action publshed re directives, regulations, and steps to report officially.

27. Teleconference With independent drs and researchers, and GW vets through VA at least quarterly.

Appendix 2 Scientific Data to support S409

PRESIDENTIAL SPECIAL OVERSIGHT BOARD
FOR DEPARTMENT OF DEFENSE INVESTIGATIONS OF
GULF WAR CHEMICAL AND BIOLOGICAL INCIDENTS
PUBLIC HEARING
Tuesday, October 19, 1999
Fort Lewis, WA

P A R T I C I P A N T S:
Secretary Jesse Brown
Rear Admiral Alan M. Steinman
Dr. Vinh Cam
CSM David
Mr. Roger Kaplan
CAPT Brian Peterman
Dr. Peter Spence r, MD
Dr. John Russell, Ph.D.
Mr. Michael Kiser
Mr. Michael Killen
Ms. Lisa Spahr
Dr. Aristo Vojdani, Ph.D.
Ms. Denise Nichols, RN
Mr. Edward Noble

C O N T E N T S
Opening Remarks
Secretary Jesse Brown
Special Oversight Board Update
Mr. Roger Kaplan
Factors that Associate with Gulf War Illnesses
Dr. Peter Spencer
Transuranium and Uranium Research
Dr. John Russell
Veteran Service Organization Comments
Mr. Michael Kiser, Disabled American Veterans
Mr. Michael Killen, Veterans of Foreign Wars
Ms. Lisa Spahr, American Legion
Multiple Chemical Sensitivity
Dr. Aristo Vojdani
Veterans Comments
Ms. Denise Nichols
Mr. Edward Noble
Final Remarks

P R O C E E D I N G S

Dr. Vojdani.
(Discussion off the record.)
DR. ARISTO VOJDANI: Mr. Secretary, thank you very much for giving me the opportunity to be here. My name is Aristo Vojdani. My Ph.D. is in the field of microbiology and immunology. I did my post-doc studies at UCLA in the field of (inaudible) immunology. I'm an associate professor at Charles Drew School of Medicine and Science and also director of Immunosciences Laboratory, which is a private clinical immunology laboratory.
During the past ten years, we had the opportunity to examine more than 5,000 clinical specimens, blood samples, from patients who have had symptomatology which you heard before called chronic fatigue immune dysfunction syndrome, or fibromyalgia; these individuals that had history of exposure either to toxic chemicals or to viruses or the combination of the two, viruses and toxic chemicals.
The symptomatologies are very much overlapping, but one thing we see in these patients is immune disorders, chronic fatigue immune dysfunction syndromes, immune disorders. And that's due to the fact that immune systems, while its system is very complicated and sophisticated -- for example, if we take the first line of defense, microphages, and we look at certain or single factor called interleukin 1, the hormone of the immune system produced by these microphages, you can see that, hat interleukin 1 communicates with the brain, with the tissue, striated muscle, smooth muscle, everywhere almost. So any abnormalities of microphages at the cellular level will affect other parts of the body.
Next slide, please. So chemicals which affect the immune system, we called them immunotoxicants. Immunotoxicants are the moderate dose levels, very low levels.
Their primary target is the immune system. Their secondary target could be other organs, such as brain and endocrine system. Modifying factors such as stress, hormonal imbalances, social stressors can alter the immune function, and that includes natural (inaudible) cell activity, T-cell function, B-cell function, microphage function. These reflect all the function of the immune system. The results of altered immune function could be immuno-suppression and the results of immuno-suppression could be increased infection or cancer or altering immunity, meaning the body reacts against itself, and hypersensitivity, which is allergy.

Next slide. Indeed, we read many, many articles recently in the scientific literature, very respected scientific literature, such as this is the cover of Immunology Today, talking about adverse immune response to xenobiotics being toxic chemicals. And the next slide, you can see the title of the article is "Allergic and Altered Immune Reactions to Toxic Chemicals or Xenobiotics." So chemicals can cause allergic reactions, altered immunity, and hypersensitivity.
Next slide. Also, the technology has moved to the level that we look at the genetic fingerprints of individuals. For example, in this case, they're talking about prescriptions for disaster. One drug could be life-saving for certain individuals; for another person, could be a killer. So pyridostigmine bromide could be given to soldiers and some of them will not have any effect on them; a few of them will have significant effect.
Next. So therefore, you and I could be exposed exactly to the same amount of chemicals and our response will differ perhaps by a hundred-fold. This is taken from Scientific American. Again, whatever I'm bringing here, it's all from scientific journals.
Next slide. The director of the National Institute for Environmental Health Sciences, Dr. Ken Holden, in one of his – the laboratories which he is associated with or working under him, they looked at the enzyme which is metabolizing benzene in our system. Benzene is a carcinogenic chemical. In ten different individuals, they found ten different levels of enzymes. Another meaning: If ten different individuals get exposed to benzene, some of them -- metabolites which they make is so much that may cause cancer; in other ones, the metabolites are a small amount and will not cause any cancer.
Next slide. Also, the issue of synergistic effect was mentioned before. Here from the Journal of Clinical Laboratory, Immunology, were two groups of mice. They gave them an allergin, a material causing allergy. Only 5 percent of the mice developed allergy, but when they exposed second group of the same kind of mice to exhaust diesel emission and then gave them the allergin, 60 percent of them developed allergies. So we should not forget the issue of synergistic effects.
Next. So we use immunotoxicological assessment. And immunotoxicological assessment, they are not done in every laboratories[sic]. They are very complicated.

Next slide. And in 1992/1993, I got involved with Gulf War syndrome, where our laboratory did 40 blood tests -- immunotoxicological panels on 45 soldiers who were ill at that time, and also 20 controls who did not go to Kuwait. But first we did under CBC, glucose, repeat liver enzyme, thyroid. And they call this part immunology. Very simple immunology; it's not complicated immunology. (Inaudible). This is what is done, I believe, in the majority of the hospitals and the soldiers. We did not find any significant differences between the two groups.

Later on, a year ago, we did the same tests on a hundred controls and a hundred soldiers, which I'm going to share with you today. Again, these tests were not different in two groups. So we move --

DR. VINH CAM: The hundred soldiers that you just redid, did that include the 45 original ones?

DR. ARISTO VOJDANI: Those are additional hundred. So I'm going to share with you the next slide.

This is the data that was on 1993, which was presented in front of U.S. Senate, where we found when we looked at T Helper/Suppressor -- these are equivalent to the accelerator in the car and suppressors are equivalent to the brake in the car. So when we look at sub-population of white blood cells, we found 51 percent of the patients were abnormal, only 20 percent of controls. This is the data from 1993. Natural killer selectivity, which are the first line of defense against cancer and viral infection, 54 percent abnormal versus 16 percent. Myelin basic protein antibodies alter immune disease against the brain, 53 percent versus 10 percent. And thyroid antibodies, 42/20, and tissue antibodies 35 and 5. Now I'm going to share with you the data. So that was what was done then. And my conclusion at that time from that pilot study -- I really need to read this for you because it's very important. What I concluded, that all these findings point towards a process that is neuro-immunologically mediated and is associated with reduced lymphocyte function on the one hand, and the production of auto-antibodies on the other. Since this is common pathway described in solvent exposure toxicity and chemical sensitivity, we strongly suspected involvement of one or more chemicals to which our soldiers were exposed during the Gulf War. Other factors which may be synergistic or superimposed,

such as
vaccines, bacterial infection, parasitic infection, and others, such as pyridostigmine bromide, should be explored in future research. That was in 1993.
So we took this kind of -- we applied this kind of methodology, which by looking
at the subpopulation of white blood cells, using one of (inaudible) antibodies
and very (inaudible) assays, out of almost 100 persons, we found for that
certain people of -- these are from 1999 data, a hundred soldiers who were sick.
And, by the way, the blood samples came to our laboratory from different clinicians where they put diagnosis: Gulf War syndrome. And then so we compared
those to the controls. And we found 40 percent versus 7 percent. You'll see
these numbers -- I have to go through the slides very fast -- that always
somewhere between 40 to 50 percent abnormal versus 7 to (inaudible) percent of
the control.
DR. VINH CAM: How were controls chosen? Just sex and age match?
DR. ARISTO VOJDANI: Sex and age match. That's all we could do.
Next.
RADM ALAN STEINMAN: But they are Army personnel, right?
DR. ARISTO VOJDANI: These are not Army personnel; they're controls.
Unfortunately, we did not have the Army personnel. Just healthy individuals of
the same age. But we'll be glad in the future to have -- originally, in 1993,
that was my condition to do that research -- by the way, I did it at no charge
-- to have the right controls. We have control soldiers versus ill soldiers, but
not in 1993. And this is the data distribution where, you know, because the
colors are not shown, although very fast through the –
- next slide, please. Then we looked at percent T-helper/suppressor ratios, that
35 percent versus 2 percent.
Next. And we look at some of these data, since this is colorful, we see that
usually in the scientific literature, they take it and mix it together and say
non-significant differences were found. But this is wrong to do it in this way.
You have to look whether -- what is the percentage of helper/suppressor ratio
lower than 1, and we found only 2 percent. And also, what is helper/suppressor
ratio greater than 2.5, when we found almost 30-something percent of those were
abnormal. So these individuals may develop auto-immune diseases because they
have these immune activation. These individuals that have immuno-suppression,
which is something very similar to immune system of AIDS patients, they have
immuno-suppression. So then their T-cells are abnormal -- T-cells

cooperate with
B-cells. Also we looked at percent of B-cell. And the same thing: 46 percent
versus 5 percent.
Next. So that was the -- and we found the numbers (inaudible) soldiers of the
body are not normal in the soldiers – in patients with Gulf War syndrome. Now we
wanted to see whether they functioned properly, so we expose the lymphocytes
from the patient as well as controls to the antigen, which is similar to a virus
or a material getting into our systems, and we found that also their function
was significantly abnormal. Fifty-one percent did not function well with those
antigens, versus only 10 percent of the controls. And that's the distribution.
Next slide. That was the T-cell function. The B-cell function also was abnormal
in 48 percent versus 9 percent.
Next slide. We'll go through these next slides, please. And then we look at
natural killer cytotoxic activity. These are, as I said, the first line of
defense against viral- infected cells and cancer cells. This is the natural
killer cell attacking a tumor cell; and the tumor cell is the Brown and the
natural killer cells are attacking the tumor. If these natural killer cells have
the right (inaudible), they will release their enzyme material, destroy the
membrane of the tumor (inaudible), and the natural killer cells can recirculate
and kill another set of tumor cells. When we look at the soldiers, we found 47
percent of them did not have the good natural killer cell selectivity. That
means they could not kill tumor cells in culture, and meaning they do not have,
really, the right cytoplasm and so forth and whatever is needed in order to kill
tumor cells. So from this, we know that chemicals can cause either immunologic
suppression or altered immunity or hypersensitivity. Overall, we can call that
immune dysregulation.
Next. So therefore, it was quite important to see whether or not these patients,
they have any signs of altered-immune disease where the body reacts against
itself.
Next. So also in the scientific literature, very well documented in relation
several drugs and medications where medication could cause auto-immune disease.
Next. So one of the cells of the body which are extremely sensitive to toxic
chemicals, and if toxic chemicals penetrate or manage to go through

blood, brain
barrier, they can bind to the nerve cells and there will be some immune reaction, like a PacMan. Those T-cells will attack the nerve cells and the nerve
cells now damaged completely; they can not communicate with the neighboring
cells; therefore, the kind of memory loss and so forth we see in our soldiers.
So when we looked at antibodies against myelin sheath, we found to be highly
abnormal in soldiers, in 36 percent versus 4 percent of the controls.
Next. We looked at tissue antibodies also, such as striated muscle, smooth
muscle; 37 percent versus 9 percent. Then we looked at markers of inflammation.
When we have -- when we encounter infection, such as bacterial or virus, we make
antibodies against all bacteria or viruses. Then antigen plus antibody form new
complexes. If liver function is good, they will be able to get rid of those
immune complexes. If not, those immune complexes can go to the kidney, can go to
the joint, cause arthritis or lupus, or some other diseases called auto-immune
diseases. Therefore, we looked at the level of immune complexes and we found 52
percent of them have highly elevated immune complexes versus 14 percent of
controls.
Next. So what we see here is some kind of immunologic dysregulation. So when the
immune system is not working properly, then the infectious agents, whether from
outside of the body or those who already are within our system, can get reactivated.
Next. And therefore, we looked at Epstein-Barr virus. As you know, Epstein-Barr
virus was mentioned as one of the causes of chronic fatigue syndrome and then
after that, after a few years, they mentioned cytomegalovirus, herpes type C.
And so we have many, many cause of chronic fatigue syndrome, but so far they
don't know what really causes chronic fatigue syndrome. We found 56 percent
versus 12 percent. And by the way, similar findings were published in Journal of
Military Medicine in 1994, where they found evidence of activation of Epstein-Barr virus.
So the next slides you will see the same results in relation to cytomegalovirus,
Herpes 1, Herpes 2, and -- next slide Varicella zoster, 55 percent versus 6
percent. Herpes type 6, which after four, five years ago, they found that it was
the cause of chronic fatigue syndrome. There we find that in 49 percent of the
soldiers versus 7 percent of controls, highly elevated antibodies.
And then we did also an environmental mold. And I have an article with

me right
there from a scientific journal where they show toxins of environmental molds,
such as aspergillus, and other environmental molds, can cause immune dysfunction
and many, many other abnormalities. So we found 52 percent versus 14 percent
have antibodies against aspergillus and other molds, which will be shown in
additional slides. Again, 58 percent and 12 percent and this is (inaudible).
These aren't just environmental molds. When we go to a building which we smell
some kind of moldy smell, that's – those are environmental molds. Then the issue
of mycoplasma – I'm sure you heard about involvement of mycoplasma. Mycoplasma
has been accused to be one of the organisms as a cause of Gulf War syndrome.
We did complete -- handled a thousand blood samples from the soldiers. And I'm
going to show you the data. The data in relation to -- mycoplasma, when enters
into the cell, stays inside. It's called intracellular microorganism. And that's
due to the fact that when -- under normal condition, when the bacteria goes into
the cells' cytoplasm or microphage, they have some kind of -- they create some
kind of bag around it where the enzymes unite with that bag and release into --
inside that bag, destroying the bacteria and the bacteria is going elsewhere.
But somehow mycoplasma manages to stay there almost forever. Where the immune
system is weakened, it can become activated and divide and attack the immune
system.
So -- next. So therefore, we have to take blood using DNA technology, collect
the blood, isolate the DNA, amplify the DNA – next slide -- and use specific
fingerprints of mycoplasma or other microorganisms we are looking for and then
identify it. And this method is thousand-fold more sensitive than serology.
That's why I mentioned before, thousand-fold more sensitive than serology. And
if it's positive, we consider it and then we confirm with other (inaudible) is
mycoplasma. Not only we can say the patient is (inaudible) how many copies,
whether it's strongly positive or not strongly positive.
Next. So here, the data. First of all, we show evidence of mycoplasma genus in
15 percent of controls, without having any symptomatology of chronic fatigue and
fibromyalgia. That by itself really is a question right there: How come they
have this organism but they do not have symptomatology? Fifty-two

percent of
patient with chronic fatigue syndrome, 54 percent with fibromyalgia --
and it's
hard to read – 40 percent of patient with rheumatoid arthritis.
And these are
the Gulf War syndrome, 55 percent. What we can see here, really,
patients with
Gulf War syndrome are no different than patients with rheumatoid
arthritis,
they're no different from fibromyalgia, they're not different from
chronic
fatigue syndrome. So therefore, can we claim mycoplasma is the cause of
illness?
No, we cannot.
Next. And then we look at subspecies of mycoplasma -- fermentans,
hominis -- the
same conclusion; that really chronic fatigue, fibromyalgia, rheumatoid
arthritis, and Gulf War syndrome, they have similar percentage of
subspecies of
mycoplasma. All these are published in scientific journals and articles
are
available to you. So, however, is it good to have these mycoplasma in
our blood?
No, definitely not. Here is an example of electromicroscopy; one of the
soldiers
where we see mycoplasma is attacking the helper cells, same helper cells
I was
talking about before. And if mycoplasma enters inside the helper cells,
that
will change the characteristics of the behavior of these lymphocytes and
they
become dysregulated. They will make different type of cytoplasm and so
forth. So
therefore, we have to treat these patients with some kind of
doxycycline,
minocycline, whatever, in order to get rid of these organisms from their
blood.
Next. So this type of organism could cause cell communication failures,
and cell
communication failures can lead to immune disorder. And that's from
Journal of
Science.
Next. So to summarize my presentation to you, what is really the cause
of Gulf
War syndrome? What is the Agent X which can affect the cells involved in
the
immune system microphagias and so forth?
With that thinking, I'm going to summarize my talk to you and conclude
with the
last slide, which is after this one. So based -- I would like to
summarize and
conclude that basic laboratory testing, such as CBC chemistry, T3, T4,
TSH, RF,
and others are not sufficient for diagnosis of Gulf War syndrome.
More advanced laboratory tests, including lymphocyte sub-population
analysis,
T-cell function, B-cell function, natural killer selectivity, myelin and
other
tissue-specific antibodies, and immune complexes are needed for a more
thorough

documentation of the immune disorders found in the ill soldiers. Antibody
detection, as mentioned before, such as serology techniques alone with DNA
technology, should be applied for detection of primary or secondary causative
agents of Gulf War syndrome.
Evidence of herpes family virus reactivation, mycoplasma infection, and the
environmental molds detection in the blood of ill soldiers indicate involvement
of these agents in Gulf War syndrome. Whether directly or indirectly, we don't
know. This similar viral reactivation, mycoplasma infection and other
environmental agents have been demonstrated in patients with chemical exposure,
chronic fatigue syndrome, fibromyalgia syndrome, and rheumatoid arthritis. These
factors do not appear to be etiologic agents but cofactors in Gulf War syndrome.
Gulf War syndrome is due to multifactorial etiology.
As we discuss in the Journal of Internal Medicine, Volume 245, Page 409 through
412, 1999, the title of that article was "A Single Etiologic Agent may Not be
Feasible in Chronic Fatigue Syndrome Patients," this theory could be applied to
Gulf War syndrome, as well.
Next slide. So this is really one of the most important slides. And if it's
possible to focus in, and that's really the summary of so while we are looking
for the X-factor, this is what I believe happened to our soldiers.
Stress is one of the major factors in here. Stress, warfare agents,
pyridostigmine bromide, vaccine, organophosphates, pesticides, insect repellant,
electromagnetic radiation, polycyclic aromatic hydrocarbons from oil well fires,
diesel exhaust, and airborne particles, every one of these -- even sand we can
add to this, because I read an article just last week that sand by itself, if
it's inhaled, could cause immune disorder in certain individuals.
So let's take some of these factors, one or all of them together. A hundred
people get exposed to them. Eighty percent who do not have genes which makes
them sensitive to these factors do not have immune abnormalities and they will
stay in perfect health. Twenty percent who get exposed to any of these or other
combination, if they have genes which makes them sensitive to these, they get
immune dysregulation. And then the viruses which I was mentioning -- EBV, CMV,
Herpes 1, Herpes 2, Herpes 6, mycoplasma and others -- become reactivated.
Reactivation of those can cause further decline in the immune system or immune
function in the patients, then, with chronic fatigue immune dysfunction

syndrome. So that's really the summary now. Are we going to wait to find what is
the agent X? I think again, I'm going to mention that we may waste our time. I'm
not saying this is not important. This is important probably for the future,
wars and so forth.
For immediate treatment of our soldiers, we know some of these factors in
combination or by themselves played very important role. And also, we know that
patients are having chronic fatigue immune dysfunction syndrome, immune
abnormalities, and so forth. Therefore, treatments immediately should be
designed for corrections of all these immune abnormalities we find in our
soldiers, and we should not wait until we find the X-factor.
And also, if we look at the other diseases anyway, almost every chronic illness
in the field of medicine right now display symptoms without knowing the cause.
We don't know what's the cause of rheumatoid arthritis, but patients get treated
for rheumatoid arthritis. The same thing for our soldiers: I think they should
get treated immediately without knowing what the agent is. Thank you.
SECRETARY JESSE BROWN: Doctor, I have to tell you, that was a fine, fine
presentation. That was outstanding. And I'm going to ask the staff to -- I want
to ask the staff to make sure that we get a summary of that so we can pass that
on to Dr. Rostker and his group
DR. ARISTO VOJDANI: Mr. Kaplan has a complete copy of my presentation.
SECRETARY JESSE BROWN: We should also make sure that the VA --
DR. ARISTO VOJDANI: I sent it to you by Federal Express last week.
SECRETARY JESSE BROWN: Can we have a copy of your slide presentation?
DR. ARISTO VOJDANI: Definitely.
SECRETARY JESSE BROWN: Dr. Cam?
DR. VINH CAM: Yes, I have -- I started having five questions, but now I have six
questions for you. The first one, a month ago for patients, did you observe the
differential response when you've used (inaudible)? In this slide, you did talk
about (inaudible). That's the first one.
DR. ARISTO VOJDANI: Let me answer one by one. I don't have a good memory as you.
First of all, if I take another hundred patients exposed to toxic chemicals and
put them side by side, the results will be exactly the same.
DR. VINH CAM: So there is a same way to plan like this?
DR. ARISTO VOJDANI: We don't have a fingerprint which is unique to the soldiers.
There is laboratory overlap. Similar to the symptomatology overlap, we have
laboratory overlap between chronic fatigue syndrome and fibromyalgia and Gulf
War syndrome. Yes, we get about half of those abnormalities, like 50 percent of
those were abnormal (inaudible) and half of them were higher than 100, meaning

that they were overactive, and half of them were underactive, below 75.
DR. VINH CAM: You don't know what that means?
DR. ARISTO VOJDANI: Some they have immuno-suppression and some they have -- so
therefore, if we mix the data together, they will not have statistical difference. But that's why you have to separate between immuno-suppression and
immune activation.
DR. VINH CAM: Okay. One of your slides was really striking. I mean, you had
really immuno-deficiency, and then the response was more than doubled. Now, is
that process irreversible?
And the next question which kinds of ties into that, did you or do you know any
clinicians that conducted like a very pilot experiment; you know, take those
patients, give them some kind of treatment, and redid the same tests? And did
you observe improvement in their response?
DR. ARISTO VOJDANI: First of all, we knew about chemical-induced
immuno-suppression many, many years ago, when I did my post-doc study at UCLA.
At that time, we're talking about chemical-induced immune dysfunction and
immuno-suppression, way before people knew about HIV in immunosuppression. We
have seen some patients when they get treated with biological response modifiers, and, you know, such as antioxidants, such as --
DR. VINH CAM: Interferon?
DR. ARISTO VOJDANI: -- interferon, interleukin 2, and many others, where you can
increase the helper/suppressor ratio from 0.7 to 1.2 by a long systematic
process. It takes about six months to a year potentially for treatment.
DR. VINH CAM: My next one: Did you do any study with PB to see whether there was
some kind of impaired --
DR. ARISTO VOJDANI: I did not do PB. It's amazing that exactly after my presentation, (inaudible) PB, one of the TV stations came to me and said, "Have
you done any studies? How did you know that pyridostigmine bromide was one of
the causes?" I said, really, that was just an intelligent guess, where --
because I'm so much familiar with toxicological chemical exposure and laboratory
testing, when you give certain type of chemical which may be more toxic to some
individuals and develop some kind of abnormalities but the others do not, and
that was really intelligent guess. I did not do any studies of it.
DR. VINH CAM: The next one: You know, your (inaudible) where you have all the
stresses and you put stress at the top. And this is a difficult question I'm
asking. Do you think of stress being the primary factor and everything follows,
or it's the other way around? You get some kind of immune --
DR. ARISTO VOJDANI: Thank you. Every one of us is influenced by our own

research
and thinking and so forth. In 1983, I did a very simple experiment. At that
time, I was exposing mice, different strains, to (inaudible), which is a very
carcinogenic chemical. And the mice were developing tumor after three months;
depends on strain, genetics, and disabilities.
We took one group of mice. We put them under stress – and don't ask me how. At
that time, really, there wasn't any review Board and so forth. And we put them
under stress and then we gave them the chemicals. The mice ended up -- for
example, in 90 days, developed tumor of this size (indicating); in 30 days
developed tumor of almost this (indicating), ten times bigger. So that by itself
shows the synergistic effect. And stress is a major factor in cancer and immune
disorders. That's why I put it on top.
DR. VINH CAM: Okay. My last point: I understand you have once offered to help
the VA do the training. Is this offer still open? Because a lot of officials
from the VA out here suggest you reiterate your offer again.
DR. ARISTO VOJDANI: I'll send you a copy of this, and in certain pages is -- my
offer is still there where I (inaudible) since these techniques or these tests
are sophisticated and the VA personnel do not know how to perform them, I will
be very happy to go to the VA hospital and train them in order to be able to do
this type of testing in our soldiers. If they are not ready, I'll be very happy
to do them at the agent cost, not for profit; just to help our soldiers. That's
documented in 1993.
DR. VINH CAM: And I want to mention, Doctor, that you have helped a lot of Gulf
War patients. I acknowledge that. That's really good. And thanks a lot for your
interesting presentation.
DR. ARISTO VOJDANI: Thank you.
RADM ALAN STEINMAN: Just a couple questions. On your last slide, you had the
X-factor plus all the potential stressors that lead to immune dysregulation,
dysfunction, in about 20 percent of the patients. Why do you even get an
X-factor? It seems that the (inaudible).
DR. ARISTO VOJDANI: I absolutely agree with you. Again, to be careful, I put
that X-factor. To me, the X-factors are in here.
DR. VINH CAM: The 20 percent?
DR. ARISTO VOJDANI: That's why I said we're wasting our time to look for
X-factors. The X-factors are in that box already.
RADM ALAN STEINMAN: And that leads to -- your last point was don't waste your
time looking for the X-factor; you have all these other stressors that

you could
develop on your own. But then you said focus on treatment. What would the
treatment be to repair the --
DR. ARISTO VOJDANI: Well, really I'm not qualified. I'm a Ph.D., as you know.
(Inaudible) I believe the treatment should be for correction of the immune
disorders. There are certain treatment for immune activation and there are
certain treatment for immunologic suppressions. And there are many members of
American Academy of Environmental Medicine or other associations who know how to
treat these type of abnormalities. I think we should consult those associations
and learn about treatment.
RADM ALAN STEINMAN: So if your thesis is correct, then the current VA protocol
on treating mycoplasma fermentans with doxycycline should lead to no result
because it's only treating --
DR. ARISTO VOJDANI: First of all, because I was just a month ago (inaudible) by
Department of Defense along with University of Washington, the only clinical
laboratory who recognized the technology to be good enough to be studying 720
soldiers, to evaluate effectiveness of doxycycline. We have to wait, really, as
you know, but I will not be surprised to come to the same conclusion that they
did.
RADM ALAN STEINMAN: I think the trial needs to be done because the anecdotal
cases (inaudible) has been a factor.
DR. ARISTO VOJDANI: Absolutely. Because this was a double-blind study (inaudible).
SECRETARY JESSE BROWN: I have one question and then I'd like to open this up to
our guests here. Mike Kiser from the DAV talked about the application from the
VA regulation, which basically says -- this is for conversation purposes. And
Jim, if I'm wrong, please correct me. But I think the regulation reads something
like this: That if you served in the Persian Gulf and you are now manifesting
residuals that are outlined -- and there are like 13 to 17 of them -- and they
are not diagnosed, then service connection can be applied. Which also means that
if they can be diagnosed, then service connection would not be applied. You
stated that some of these immune deficiencies can trigger things like arthritis,
which is a diagnosed condition.
DR. ARISTO VOJDANI: Yes.
SECRETARY JESSE BROWN: But it appears to me, from a lay standpoint, what you're

also saying is that they can be indirectly related to the so-called Persian Gulf syndrome.

DR. ARISTO VOJDANI: Yes. And with that -- I would like to add I don't understand why we cannot make diagnosis of Gulf War syndrome, because many doctors are already doing that, and make the insurance companies to accept Gulf War syndrome as an illness, including Medicare.

SECRETARY JESSE BROWN: Well, the VA treats it, for adjudication purposes, as a symptom, because historically the regulation says in order to receive compensation, it has to be a disease. And some of the symptoms, such as headaches, muscle pain, joint pain, those are more symptoms as opposed to a disease and, therefore, under the old regulation, they didn't qualify. But based upon the new policy that went into effect about three years ago, the VA has now service-connected those conditions. But at the same time -- getting back to what the problem is -- is that if some of these problems end up being diagnosable, then the veteran cannot receive compensation for it. But here you are saying that some of these problems here, such as stress, the warfare agents, PB, and so forth, can cause or trigger conditions that are diagnosable, such as arthritis and that kind of thing. Is that correct?

DR. ARISTO VOJDANI: I didn't say that. I didn't say that, no. What I said is that (inaudible) cause immune abnormalities which similar immune abnormalities also found in patient with arthritis, which is immune activation, or immuno-suppression, which is found in patients such as AIDS or HIV. But they are not typical enough to call them arthritis or other illness because when you do -- in order to have arthritis, according to the College of Medical Pathology and Rheumatology, you have to have certain parameters to define arthritis. You have to have joint pain, rheumatoid factor, and many, many other – these are atypical diseases. They will not fit in the box of arthritis. They will not fit in another box. So these are unique group of abnormalities which are special to Gulf War syndrome, chronic fatigue syndrome, and fibromyalgia.

SECRETARY JESSE BROWN: I got it. Are there any questions that the audience would like to ask Dr. Russell or Dr. Vojdani at all?

UNIDENTIFIED SPEAKER: Yes, sir. To follow up on what you said there, Mr. Secretary, when I see younger guys that were in the Gulf, even 26, 27 years old, the degenerative arthritis seems to be the prevalent one. Not just the

young
guys, but anybody you talk to. You name it -- say arthritis and they say, yeah,
degenerative arthritis. Does that fall in that category?
DR. ARISTO VOJDANI: Well, they have symptoms similar to arthritis, but when you
do further study, they do not fit to have the classical arthritis. Therefore,
these are unique type of diseases.
UNIDENTIFIED SPEAKER: What I'm saying is, under the diagnosis from VA, everybody
has a claim for degenerative arthritis, whether he's 27 or 47. That's one of
these claims that's been adjudicated for degenerative arthritis.
SECRETARY JESSE BROWN: Under the rules, the VA can service-connect degenerative
arthritis under two regulations. One, if the condition is shown concurrent with
his or her active duty or developed to a 10 percent or more disabling within the
first year of discharge.
Did I get that right? Is that correct? So under those circumstances, service
connection can be applied. But what I'm talking about, and the doctor explained
it to me, is that we're talking about a guy that's been out of the service for,
let's say, six years, he served in the Persian Gulf, and he now feels that his
joint pain is secondary to his service in the Persian Gulf and he goes into a VA
hospital and they diagnose it as arthritis.
And what you just explained to me is that the VA's current interpretation will
be correct because the guy does not have degenerative arthritis. He has
something that looks like it. But on the other hand, a good service officer will
argue that that is still consistent with the regulations governing the Persian
Gulf. (Inaudible) help me out on that.
MR. MARSHALL BOYD: You're absolutely right, Mr. Secretary, regarding service
connection on a direct basis. Where we come up against it under 38 CFR 3.317,
that regulation, is that it has to be undiagnosed. Since the point has been made
many times now, it has to actually be undiagnosed. So if the diagnostic criteria
for arthritis are met, the VA or another physician diagnosis arthritis, we
can't, under 3.317, grant service connection for that condition. We might be
able to do it on a direct basis or on a secondary basis, but not under 3.317.
And that point is made by Mr. Kiser and several other people.
SECRETARY JESSE BROWN: Thank you. Do we have any other -- yes, sir.
UNIDENTIFIED SPEAKER: Doctor, you mentioned that you had done some studies
injecting allergins into mice and you had further exposed them to engine
exhaust. Did you do any studies with vaccinations?

DR. ARISTO VOJDANI: That wasn't my study. That was published in Journal of
Medical Pathology and Immunology, a slide taken from that. And I presented it
for showing the synergistic effects of chemicals. And we have many, many publications similar to that.
UNIDENTIFIED SPEAKER: Have you done anything with the vaccinations?
DR. ARISTO VOJDANI: No, I didn't.
SECRETARY JESSE BROWN: Any other questions, ma'am? Ma'am, do you have any other
questions?
UNIDENTIFIED SPEAKER: No, that's all.

Appendix 2 continued

Exerpts From Presidential Oversight Board in Seattle

I am certain that the committee is knowledgeable of House Veterans Affairs
Committee Chairman, Bob Stump's Secretary to -- or a letter to Secretary Togo
West, where he suggested that perhaps the agency has narrowly defined Persian
Gulf War illnesses -- or undiagnosed illnesses. It's dated June 3rd, 1998. He
indicated that Congress's intent was to service- connect Persian Gulf War
veterans who suffer from symptoms of illness which cannot be clearly defined.
And this is inconsistent with the provisions of 38 USC 3.317 as it applies to
Persian Gulf War veterans.
So we would ask that perhaps the committee can endorse the letter from
Congressman Stump's office to Secretary Togo West, that the agency should
revisit their regulation on how Persian Gulf War veterans' claims are adjudicated.
The Veterans Administration, under the direction of former Secretary Jesse
Brown, acted quickly and decisively to treat and compensate Persian Gulf War
veterans for undiagnosed illnesses thought to be related to their service in the
Persian Gulf. However, to this date, 7,749 claims for undiagnosed illnesses have
been filed under 38 USC 3.317. Only 2,934 claims have been granted. Well, if one
takes that percentage of 697,000 veterans and only 2,934 have been granted,
that's a percentage of four one- thousandths of a percent.
We recognize that the agency has made a genuine effort to address health-care
issues and claims adjudication associated with PGW veterans. However, it appears
that the Persian Gulf War veteran is disadvantaged by the very system that's
designed to help him.
To highlight Congressman Stump's letter, it indicates on June 3rd, 1998, as
Congress continues to hear from Persian Gulf War veterans who believe their
health-care problems are of service origin, it has become increasingly apparent
to us that the department is too narrowly implementing the landmark legislation
initiated by this committee to provide compensation to the veterans.
The Persian Gulf War Veterans Act in 1994 provided for the payment of
compensation to Persian Gulf War veterans suffering from chronic disability
resulting from undiagnosed illnesses, which become manifest or compensable to
grieve within a period described by this regulation. VA regulations implementing

outside our mandate, but I'm going to instruct the staff to take a very, very
close look at this and also consult with our attorneys to see if we can express
an opinion. At least write the VA and advise them that there is some question on
whether or not they are interpreting the intent of the Congress (inaudible).

SECRETARY JESSE BROWN: All right. That's what it's all about. Working together. We have Denise -- my good friend Denise Nichols wants to share her observations with us.

(Discussion off the record.)

MS. DENISE NICHOLS: Thank you, Mr. Brown, and each of you honorable men and women for being here (inaudible). The charter of the commission was reviewed earlier, the two principal roles that you all were here under. I'd like to point out that under one of those roles that you had was to review possible detections of and exposures to chemical or biological warfare agents and environmental and other factors that may have contributed to the Gulf War illnesses.

We've gone a long ways since '93, since the first hearings on Capitol Hill. But we came out of the PAC with a recommendation that an independent body look at this. We ended up, yes, with a compromise politically, that we have the Oversight Board. We still feel like the process could be somewhat better. We're happy with how things are going pretty well with the Oversight Board and the interim report, although we still feel that there's -- the process is still driven by the DoD. The DoD -- we feel a loss of trust still with the DoD. We understand and we even spoke of the need to have the DoD involved in this process as we go along because they do have to rebuild that trust to continue our national security. But we are still having problems with that. We're still looking for (inaudible) to be more independent or to have another group be more independent.

So we're progressing, I guess, if we have a scorecard, with the interim report coming out. It's getting there. It's very trying for the veterans to live through this because the war was in '91, although it's continued on. So we've been asking for help for nine years. So there's a lot of frustration, a lot of mistrust. Our belief systems have been affected. It's almost like being raped by your own country.

Some of us keep trying. We keep holding in there with you all. A lot of people have been dropping off along the way. We're very concerned about that. We're very concerned about that trust and rebuilding that. Not a whole lot of (inaudible) is being made on that. And my concern is we don't want to lose a lot more to suicide.

So I want to bring up where we've come from and a kind of grading system with where we are, and very politely and with respect to the work that's being done. But the PAC defined when they turned in their report that investigations to date were superficial and likely to provide credible answers to the veterans and the public's questions. We're improving, but we're not totally there yet. We still have contention on a lot of items, (inaudible) being one of them. I'll have a few suggestions here to add to that. I've made notes as we've gone through and altered my testimony.

Let's see. Where do I want to go here? We still have concern about Mr. Rostker having sufficient time to devote. And this is a big issue with Gulf War veterans. He's still second in command with the Army, the Secretary. And so we're still wondering if we're getting the total commitment that we need. And the vets need to see that, that we have total commitment by the people that are put on boards and commissions. And I think there's

been some concern with the former Senator Rudman. I mean, he's got other commissions. We're very concerned that people devote their time and let's get to the bottom of this. So we have concerns with Admiral Zumwalt being out. We wish him to recover quickly, but do we need to supplement the Presidential Oversight Board? Do we get to get more help staff- wise so we can get through these things in a timely manner? That is our concern as veterans.

We feel that the anthrax vaccine or all vaccines – I'm not talking about just anthrax vaccine, but all vaccines – need to be under that other factor; that is, under the charter. And that has not been really done fairly. I have mentioned up on The Hill and in other testimony that we need -- on the registry, we need to identify people that got vaccines here in the States and yet did not deploy and that are sick. Now, they may have had other contact with exposed equipment or with providing care for people coming back from the Gulf. But we need a registry for those people because it might, you know, help us sort this out. I agree with Dr. Ari Vojdani and always have since we met at NIH in '94, wherever we met. During our paths, we've crossed several times. But the veterans have always said it was multiple exposures, and it's multiple symptoms and multiple exposures. So I agree fully with him. But I'm very concerned on the vaccine issue, because we have too many vets that I've talked to that don't -- they weren't deployed. And that's what this lady has brought up, not being able to get on the registry because they weren't in the Persian Gulf theater of operation. Now, we may need to code them differently, but we need those people. We need to study and see if they're coming out the same way as we are. The people that have taken the vaccine and are having reactions on the current force, we need to include those and see if there's something there.

Our active-duty forces are speaking up. Our pilots are leaving because of that. That's a lot of training money that the taxpayers paid. And it's not being recorded that they're leaving because of that reason, because the military won't let them report it that way. Okay?

So we have a problem, and the true communication with the leadership is not being heard. And I'm trying to be a logical, thought-provoking person here to say we need to look at those vaccines under other factors, pull in our active duty that got shots, that got sick, because we've had several of them go into the hospital with reactions. And we need to do some of these leading-edge research to see if it falls under there. Then we need to pull back and have a moratorium for a while and rethink this as scientists and medical people and give better input into our leadership of our active-duty forces, because for certain, we do not want to repeat any errors that were made, no matter if they weren't recognized as errors and they were done. In wartime, you make the best decisions you can at that time and you move forward. And I think that's what's happened with the Gulf War, is we made the best decisions at the time with the vaccines, the pills, you know, although there was a lot of research there that makes us rethink it. But we have sick people; they need to be cared for. We have active-duty troops that are refusing vaccine. And I don't think you can separate them and keep them separate issues.

So my thought is we need a different roster, a registry for these people. We need to get them with some of these researchers right now, get answers for that. Because we as veterans were proud of serving and would want to -- we want to help solve the problem, too. Okay? It's our lives that have been affected so much, and we will be a part of this. As you know, I've said that before.

But in your interim report, there was only very limited remarks on the vaccines. And it clearly said something about other factors. The RAND study was a review basically of the

legality of informed consent. It didn't do any research on long- term effects or what was there or anything like that. So it's been very limited coverage on the vaccines. And we have not seen any plan to include the vaccines in that study. And we need to because we are continuing on with a mandatory anthrax vaccine program.

I have looked at it. If I was still active duty, I might refuse to take it, too, sir, and I was a nurse. And we have a lot of medical people that when you start giving them the shots, they're going to do like the pilots are. They're going to be out the door. Okay? So we need to look at that other factor, other charter, and recommend some studies on plan on vaccines. GAO has identified that on The Hill. There has been eight hearings I believe now with Congressman Shays' committee and with Burton's committee and the Armed Services Personnel Committee – subcommittee under Congressman Buyer. There is a lot of attention being paid to this. It started with the Gulf War. We got vaccines, other things, and we need to include that in your plan to oversee the DoD. I'd like you to really put that down into the plan. And Rostker and OSAGWI and everybody over at DoD should be involved. And I've detailed all that about the vaccine in the written materials, so I'm not going to go over that because it can be easily ready, and I've summarized it well.

I will say that the oversight that we're having here on this project and the questions that come up in every hearing make me think that we need an oversight committee on VA care and claims problems that have been surfacing with the Gulf War vets. This isn't really under your charter. You've got the expertise and have helped greatly in bringing in the VA people. But that's a big problem, and I think that we need a committee to deal with that and go to the community like you all have or like the PAC has, to deal with those problems to give back the recommendations of how to correct them.

Needs

I think that we need triage in the VA system. We have some Gulf War vets that are very, very ill, and we need emergency care for them and emergency supplementation for those families. If it's not direct, then maybe we need some personal waivers or something, because we have to fulfill the need for the vets. And one of the examples I'll use is (inaudible), but a POW from the Vietnam War, Colonel Ted Guy, who died five months ago. He had a cancer and they put in an emergency claim for Agent Orange-related. It didn't get worked. Here we had a man who served our country; almost the ultimate price of death on the battlefield, several years in the Hanoi Hilton, and he died. And he put in a claim through the VA and we didn't come through for him.

I think that kind of is an example that we have to keep in mind. We need a triaging system just like we had in combat, and we need to find a way to solve these problems so the vets don't walk away feeling betrayed. We have vets of the Gulf War that the (inaudible) was set up was to provide care for them. They come into the VA and before they put a claim in -- they may still be active reservists and they're going to the VA because they have symptoms of Gulf War syndrome, and they get a bill. I don't think that's what the sense of the Congress was, and we have to go fight those (inaudible) when they crop up across the nation. We have problems with the antibiotics. Whether they believe in it or not, it's unequal. When you have the research study -- and for example -- I'll use Denver as an example. Denver is not part of the research study. So if we have vets in Colorado that wanted to participate in that study, they can't. And that's not right. That's saying there's not availability of research in an area. And all vets should have equal access to their research studies and to the benefit that it may help them. So we need to look at that. We need veteran input to research priorities. The press asked me tonight, "What would you see as research priorities?"

Number one, we have family members that have developed illnesses that parallel what the veteran has. We need to find out what's going out in those families, in the highest order. If we brought something back, a biological or whatever, that's been transmitted to the family, that should be number one because it's going beyond the veteran. So that should be a number one research study.

Number two would be the reproductive problems that are occurring and involvement of reproductive organs, for research monies. We need to expand Dr. Haley's neurological findings and have that available.

I was very unhappy at the federally sponsored research conference when one of the VA people -- and I was shocked when they did this -- after so much funds were spent on that research and there was so much excitement to, Let's see if we can go out and find this enzyme and this brainstem damage. And basically the VA said, "It's just research and we can't do it at the VA." That's not an appropriate answer, as far as I'm concerned. We've gone too far in pushing medical science to find answers, to say, well, when a project is done, that we can't do it anymore. Find a way to implement it at the local VAs. There's a lot of things that we need to look at, but that is -- and it has been above and beyond the scope of your charter. So I'm recommending that -- and I'm surprised it wasn't in your interim report -- identifying that as a problem from your Oversight Board and passing it up to the White House and seeing if we can start something to get the care and treatment started. We have FEMA that goes out and does that for disaster victims, but yet our vets have to wait nine years? Something's not right here. It's terribly wrong. Because we went to war nine years ago and we've been saying we need immediate, urgent attention this. Well, we're getting research funds, but that doesn't really help the vet. What helps the vet is for you to listen. And, you know, if the vet brings in independent testing, to say, "Whoa, where did you get this from?" Dr. Ari Vojdani, I've been tested by him. I took in my lab results and I said, "Here, this is real." Okay? I got hard proof now," to the doctor. And I was offered psych drugs. And I said this is getting really frustrating, you know. I'm not asking for psych drugs. I'm not asking for pain pills. I'll keep going, but I want to find a way to get those values on the herpes viruses back down, try to get holistic balance back in my body. And I don't get any help from the VA. So that's what the vet is looking for. And it never was really about money, except that if you can't work, you need that assistance. And if you were used to a two-income family and you've got one and now your wife or your spouse is getting ill, too, or your little daughter is ill and wasn't before and they can't figure out what's going on, that's the priorities. And I thank you for listening to me. And I did divert from my testimony because I always come to the meeting and try to summarize at the end to bring it home to you. Thank you very much.

SECRETARY JESSE BROWN: You're very good. Thank you so very, very much, and good seeing you again. We appreciate your comments and observations. And I would like at this time to thank all of the presenters. Also thank the Fort Lewis's facility, the veterans that are here. And I'm going to ask just one additional time if there are any other people here who would like to make any comments, just raise your hand.

Dr. Vojdani?

DR. ARISTO VOJDANI: The issue of vaccination really is a very sensitive issue. It happened that last week I was in a medical convention, and not far from here, Coeur d'Alene, Idaho, where international scientists from England, Australia, United States, they shared some concern about vaccination of children. And I know -- I have three children and almost grandchildren and all of you have also children, probably. The recommendation

for the future is not to give three or four antigens at the same time; to give one at a time. Because what happens really to children who develop autism, for example, which is claimed to be partly induced by the vaccines, is when the immune system is not mature enough and you overload it with all these bacterial antigens, that child is going to end up with some kind of immune disorder or with some kind of disease. So therefore, I want you to take with you home, please, if you – I'm not saying do not immunize. I would not dare. Immunize, but one at a time.

In adults, if you want a model of arthritis, take a little bit of bacteria and inject it into a rat or a rabbit, and the rabbit will develop in three months arthritis due to just simple injection of bacterial antigens. What is a vaccine? Vaccine is a bacterial antigen. So what I'm trying to say is that if we give those bacterial antigens to all individuals, to say these individuals are equal, the end result will be 20 percent of them will develop disease, 80 percent, again, according to that formula. I believe there should be some kind of screening prior to that. If they have perfect immune system, immunize them. If they have immune activation, if you immunize them, they will develop some kind of auto-immune disease in the future. Thank you.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN REYES TO DEPARTMENT OF VETERANS AFFAIRS

Follow-up Questions for Honorable Joseph Thompson

Under Secretary for Benefits

House Veterans Affairs Committee

Subcommittee on Benefits

From Rep. Silvestre Reyes

July 10, 2001 hearing

1. How many Gulf War Veterans have been granted service-connected compensation benefits for chronic fatigue syndrome and fibromyalgia?

Answer 1: Our data show that 406 Gulf War veterans have been granted service connection for chronic fatigue syndrome. Our data show that 694 Gulf War veterans have been granted service connection for fibromyalgia.

2. How many Gulf War Veterans have been denied service-connected compensation benefits for chronic fatigue syndrome and fibromyalgia?

Answer 2: Our data show that 1,709 Gulf War veterans have been denied service connection for chronic fatigue syndrome. Our data show that 422 Gulf War veterans have been denied service connection for fibromyalgia.

3. Has VA determined what amount of time is a reasonable time for veterans calling VA on its toll free numbers to reach a veterans service representative?

Answer 3: Customer Service Standards of the Department of Veterans Affairs (VA) includes the following timeliness standard for VBA: "We will respond to telephone calls within three minutes after the call goes through." This document is available through our website at: www.va.gov/customer. We believe, on average, most calls are answered in less than three minutes. In FY 2001, VBA answered 92 percent of calls within three minutes.

4. Does VA track waiting times for callers on its toll free lines in additions to blocked call rates? (If yes, please provide that information)

Answer 4: Although this information may be tracked locally, VBA does not collect this data. (See above response.)

5. Does VA have any toll free numbers for veterans in emergency situations or needing crisis intervention? (If yes, please provide that information)

Answer 5: VBA does not have specific toll free numbers for veterans in emergency situations or needing crisis intervention. VBA's core telephone business pertains to benefits issues, which do not require 24-hour accessibility. However, VBA's veterans service representatives who answer calls to VBA's toll free number refer callers to other VA facilities, state and local government agencies or other community resources for non-medical emergencies or crisis situations. In addition, regional offices are required to identify, for priority handling, claims of veterans who are terminally ill, homeless, or have been identified as being financially destitute. Individuals, teams and managers monitor these special cases throughout the duration of the claim to ensure the claims receive expedited processing at each step of the claims process.

6. Since VA has a contractual obligation to pay all death claims for veterans holding VA life insurance, please explain how VA calculated a "pay-go" cost associated with the provision for payment of alternate beneficiaries?

Answer 6: OMB Branch representatives reviewed whether the alternate beneficiary legislative initiative would have PAYGO affects. The decision by the Budget Review Division within OMB was consistent with all scoring that has taken place prior to this. These prerequisites are mandated by the Budget Enforcement Act and described under 20.9 of OMB Circular A–11. Essentially, the controlling factor is increased outlays in near-term years. Neither the Budget Authority nor the appropriation is the controlling factor in PAYGO—outlays are. Whenever a mandatory ac-

count has legislation proposed by an authorizing committee that increases (or decreases) spending, i.e. outlays, PAYGO is set in motion, requiring a corresponding offset in mandatory spending somewhere across Government in order to avoid a potential sequestration order at the end of the session of Congress.

Since VA holds approximately $23 million in liability and it is expected to locate and pay on approximately two-thirds of the 4,000 cases, about $15 million will be paid over a 5–year period, notwithstanding the three-year wail to pay these liabilities. Then, about $2 million will be added each year, which would normally have been placed into liability, to aggregate to $25 million over a ten-year period.

CONGRESSMAN EVANS TO DR. JOHN FEUSSNER

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

AUG 2 8 2001

In Reply Refer To: 12

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

Thank you for your recent letter concerning Department of Veterans Affairs (VA) sponsored research on the prevalence of illnesses experienced by Gulf War veterans.

I have enclosed a table on the seven relevant projects that includes a brief description of the illnesses being studied, the grantee, the amount of the grant, the results of the research, and the date of completion. The table also includes information on the 14 relevant projects that the Department of Defense (DoD) and the Department of Health and Human Services (HHS) have funded. VA and the two Departments have closely coordinated their Gulf War research efforts through the Research Working Group of the Interagency Military and Veterans Health Coordinating Board.

The Research Working Group provides oversight and coordination of the 193 projects related to illnesses in Gulf War veterans, funded by VA, DoD and HHS, at a total expenditure of $174 million. The overall research portfolio is so extensive that it is difficult to summarize in a table; therefore, I have also enclosed the *Annual Report to Congress on Federally Sponsored Research on Gulf War Veterans' Illnesses for 1999*. This report provides detailed information about each project.

I appreciate your interest in this important research, and thank you for your continued support of our Nation's veterans.

Sincerely,

Thomas L. Garthwaite, M.D.
Under Secretary for Health

Enclosures

Summary of Research Related to the Frequency of Illnesses in Gulf War Veterans

Department of Veterans Affairs Office of Research and Development
August 2001

This summary was prepared in response to a request made in a July 25, 2001, letter from Congressman Lane Evans to Dr. John Feussner. The request was as follows:

> "Please provide a list of all VA sponsored research completed or currently underway concerning the prevalence of illnesses experienced by Gulf War veterans. Include a brief description [of] the illness or illnesses being studied, the grantee, the amount of the grant, the results of the research and the completed or expected completed date."

Abbreviations:

ALS	amyotrophic lateral sclerosis (Lou Gehrig's disease)
CD	cognitive dysfunction (memory and concentration problems)
CDC	Centers for Disease Control and Prevention
CFS	chronic fatigue syndrome
DEC	decrease
Diff	difference
DoD	Department of Defense
Dx	diagnoses made through medical and/or psychiatric evaluations
FM	fibromyalgia
GWV	Gulf War veterans
HHS	Department of Health and Human Services
Hosp	hospitalizations
INC	increase
LBW	low birth weight
MCS	multiple chemical sensitivity
MD	major depression
NDV	non-deployed veterans
NHRC	Naval Health Research Center, San Diego, CA
PN	peripheral neuropathy (damage to nerves in arms and legs)
PTSD	posttraumatic stress disorder
Qaire	survey questionnaire
SA	spontaneous abortion (miscarriage)
Sig	statistically significant (increase or decrease)
SLE	systemic lupus erythematosus
Srill	self-reported illnesses
Sx	self-reported symptoms
Time 1	initial test period in a longitudinal study
Times 2, 3, 4	subsequent test periods in a longitudinal study
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center

Funding Source, Project Number	Name of Study Director, Institution	Funding (Dollars)	Expected Completion Date	Type of Study & Illnesses	Results, if Available
VA-1	Han Kang, Washington VAMC	3,998,000 (VA-1, 2A, 2B, combined)	(follow-up will continue indefinitely)	Rates & causes of mortality	No diff in death rates in GWV and NDV for nearly all diseases (e.g. cancer or heart disease); sig DEC in infectious disease deaths in GWV; sig INC motor vehicle deaths in GWV; overall death rates in both GWV and NDV are only 41% of death rates in general US population
VA-2A, 2B	Han Kang, Washington VAMC	(see VA-1)	March 1999	Qaire (several SRill & 48 Sx)	No diff in rates of serious SRill in GWV and NDV (e.g. cancer, heart disease, stroke, diabetes or cirrhosis); sig INC in all 48 Sx in GWV, compared to NDV
VA-2C	Han Kang, Washington VAMC	10,973,000	October 2001	Dx made by medical exams (CFS, FM, PTSD, CD, PN, & asthma in vets; birth defects in children)	Study ongoing
VA-7	Jessica Wolfe, Boston VAMC	50,000	September 1995	Qaire (PTSD, MD)	Time 1 Qaire and Time 2 follow-up of Fort Devens cohort; at Time 1, sig INC of Sx of PTSD in GWV who were female, younger age, enlisted, or Reserve/National Guard; sig INC in Sx of PTSD and MD in GWV from Time 1 to Time 2
VA-4	Jessica Wolfe, Boston VAMC	2,830,800	March 2000	Dx from medical & psychiatric exams (PTSD, MD, CFS, MCS); neuropsy-chological tests (CD)	Time 3 follow-up of Fort Devens cohort; sig INC in rates of Dx of PTSD and MDD in GWV, compared to NDV; no diff in rates of Dx of CFS and MCS between GWV and NDV; no diff in rates of Dx of CD (on neuropsychological tests) between GWV and NDV

DoD-52	Susan Proctor, Boston VA	414,000	July 1999	Qaire (PTSD MD)	Time 4 follow-up of Fort Devens cohort; study ongoing
VA-12	Patricia Sutker, New Orleans VAMC	(unfunded)	September 1997	Qaire (PTSD, MD)	Time 1 Qaire and Time 2 follow-up of New Orleans cohort; sig INC of Sx of PTSD and MD at Time 1 in GWV, compared to NDV; sig INC of Sx of PTSD in GWV from Time 1 to Time 2
VA-61	Ron Homer, Durham VAMC	1,263,000	July 2001	Dx of ALS by medical exams	Study ongoing (same as project DoD-118)
HHS-1	David Schwartz, CDC and state of Iowa	3,544,000	April 2001	Qaire (several SRill & Sx)	Time 1 Qaire of Iowa cohort; no unique "Gulf War syndrome;" sig INC in GWV, compared to NDV in: CFS, FM, MCS, asthma, CD, PTSD, MD, & alcohol abuse; among GWV, INC rates of most SRill in Reserve/National Guard
DoD-58	Brad Doebbeling, University of Iowa	2,208,000	September 2001	Dx from medical & psychiatric exams (FM, MD, asthma); neuropsy-chological tests (CD)	Time 2 follow-up of Iowa cohort; Study ongoing
HHS-2	William Reeves, CDC and states of Florida & Penn.	766,000	June 2000	Qaire (35 Sx)	No unique "Gulf War syndrome;" sig INC in rates of 34 of 35 Sx in GWV, compared to NDV; among GWV, sig INC in rates of Sx in females, older age, enlisted rank, & smokers
HHS-6	Howard, Kipen, CDC, RW Johnson Med School	2,000,000	October 2001	Qaire (CFS, FM, MCS, MD, PTSD)	Study ongoing

DoD-1A	Greg Gray, NHRC	8,639,000 (for all parts of DoD-1)	October 1997	Qaire (41 Sx); pulmonary function tests (PFT)	No unique "Gulf War syndrome;" sig INC in 35 of 41 Sx in GWV, compared to NDV; sig INC in Sx of PTSD and MD in GWV, compared to NDV; no diff on PFT in GWV and NDV
DoD-1B	Greg Gray, NHRC	(see DoD-1A)	October 1998	Rates of hosp in all DoD hospitals (all causes; FM, ALS, & SLE)	No diff in rates of 13 of 14 major categories of Dx in GWV and NDV; sig INC in rates of mental disorders (alcohol abuse, drug abuse, & PTSD) in GWV, compared to NDV; sig INC in rates of FM in GWV, compared to NDV; no diff in rates of ALS or SLE in GWV and NDV
DoD-1C	Greg Gray, NHRC	(see DoD-1A)	October 1997	Birth defects in children	No diff in rates of birth defects in children of GWV, compared to NDV (DoD hosp nationwide)
DoD-1D	Greg Gray, NHRC	(see DoD-1A)	September 1999	Qaire (infertility, SA, LBW)	Study ongoing
DoD-1E	Greg Gray, NHRC	(see DoD-1A)	September 1999	Qaire (several SRill & Sx; CD)	Study ongoing
DoD-1F	Greg Gray, NHRC	(see DoD-1A)	September 1998	Rates of hosp in DoD, VA, & civilian hospital systems (all causes)	No diff in rates of most of 14 major categories of Dx in GWV and NDV; sig INC in DoD & civilian hosp for fractures and soft-tissue injuries in GWV, compared to NDV; sig INC in VA hosp for respiratory system and digestive system Dx in GWV; sig DEC in all 3 hosp systems for infectious disease Dx in GWV, compared to NDV
DoD-1G	Greg Gray, NHRC	(see DoD-1A)	June 1999	Birth defects in children	No diff in rates of birth defects in children of GWV, compared to NDV (all DoD and civilian hospitals in Hawaii)

DoD-39	Simon Wessely, King's College, London, UK	1,173,000	October 2000	Qaire at Time 1 (several Sx & SRill); Dx at Time 2 made by medical & psychiatric exams & neuropsy-chological tests	Time 1 Qaire and Time 2 follow-up of British GWV, NDV, and Bosnia veterans; no unique "Gulf War syndrome;" sig INC in GWV compared to NDV in 50 of 50 Sx and several SRill (e.g., CFS, MCS, PTSD, CD, asthma, arthritis); sig INC in Sx among GWV who were enlisted or smokers; medical exams at Time 2 ongoing
DoD-45	Penny Pierce, University of Michigan	200,000	August 1999	Qaire (several Sx, PTSD, MD)	Time 1 Qaire and Time 2 follow-up of female GWV and NDV in Air Force; at Time 1, sig INC in several Sx in GWV, compared to NDV; at Time 2, sig INC in different types of SX in GWV, compared to NDV; sig INC in PTSD, but not MD, in GWV, compared to NDV

(These reports are retained in committee files.)

Department of
Veterans Affairs

ANNUAL REPORT TO CONGRESS

Federally Sponsored Research on Gulf War Veterans' Illnesses for 1999

April 2001

The Research Working Group of the Persian Gulf Veterans Coordinating Board

Department of
Veterans Affairs

ANNUAL REPORT TO CONGRESS

Federally Sponsored Research on Gulf War Veterans' Illnesses for 1999

APPENDICES

April 2001

The Research Working Group of the Persian Gulf Veterans Coordinating Board